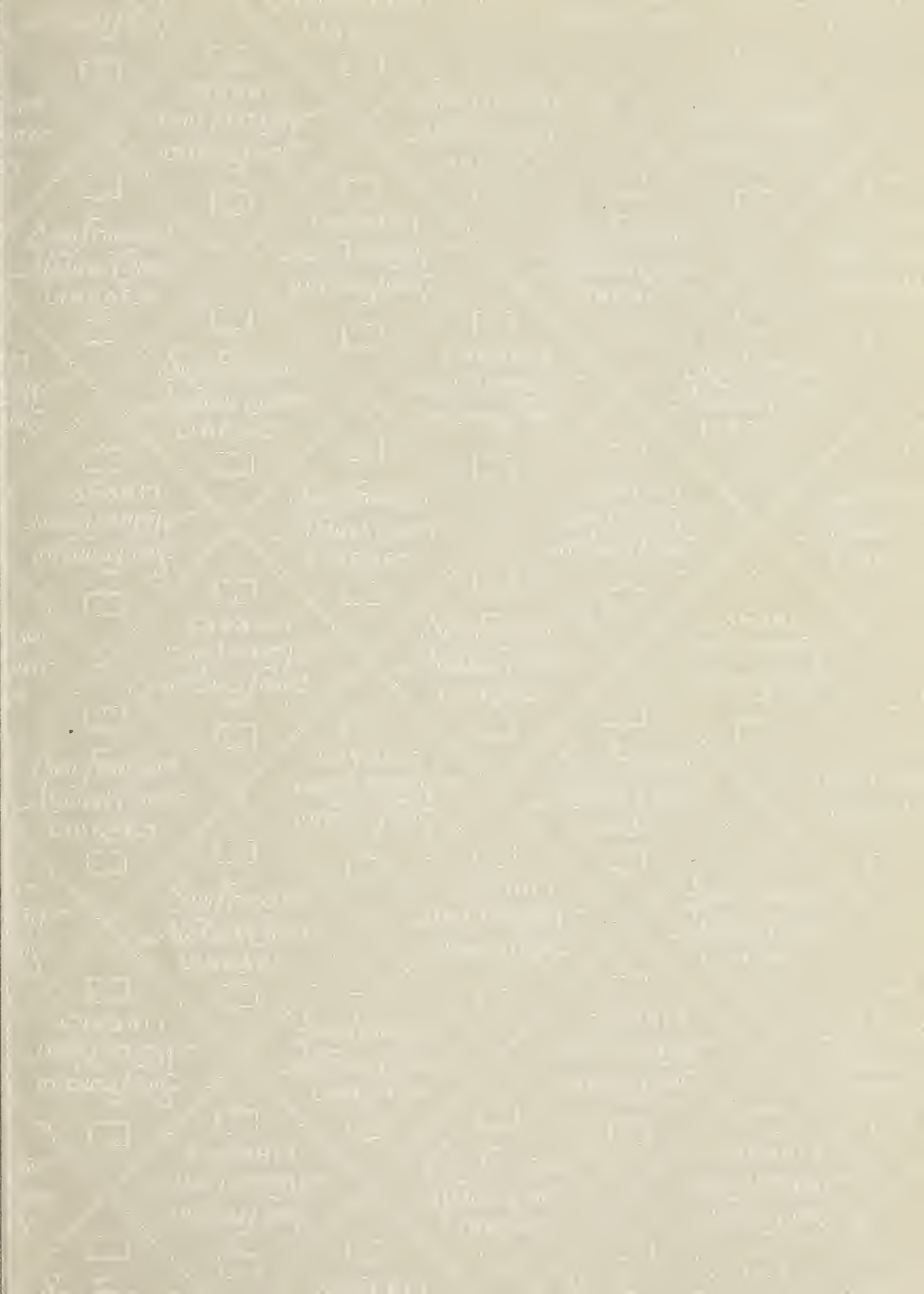

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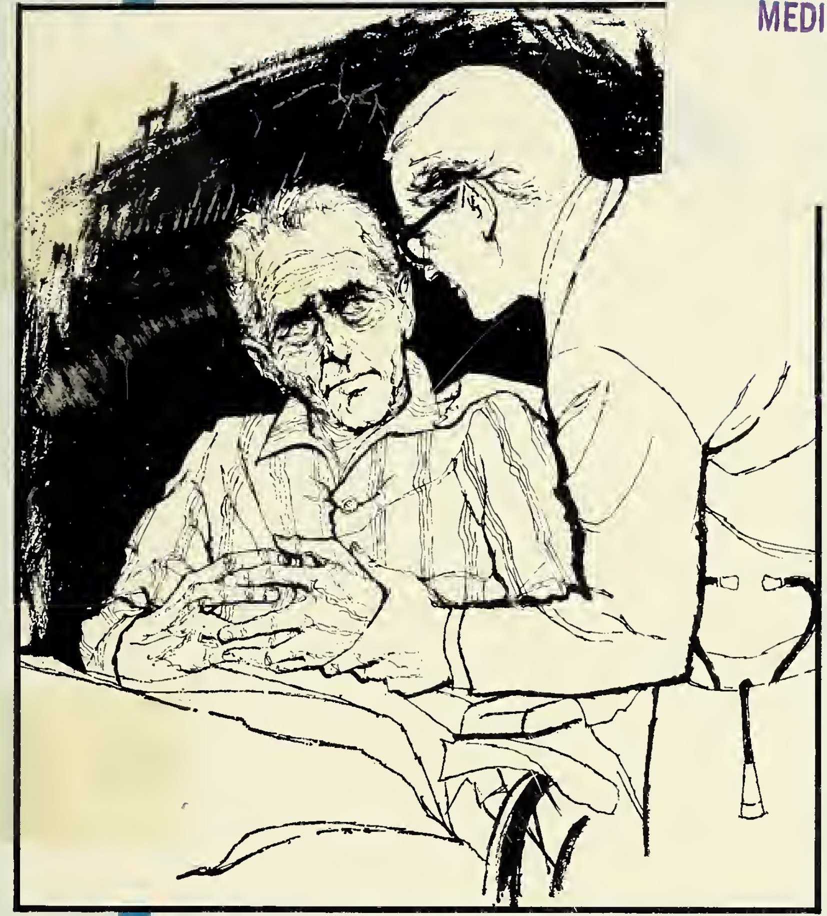

Impact of Medicare on the delivery of health care in Michigan

Summary of abortion law reform progress in Michigan

Pros/Cons of professional incorporation

Listing of MSMS committee chairmen

Scientific article on hypertension

Michigan State Medical Society
January 1970, Volume 69, Number 1

261223

The girth control pill

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO Inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON·MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

January 1970, Volume 69, Number 1

Michigan State Medical Society

michigan medicine

Breaking News

DO SPECIALTY BOARD ACCEPTANCE ADOPTED

AMA House of Delegates in Denver Acts on Six Michigan Resolutions

Michigan's Delegation to the AMA Clinical Meeting, held in Denver on December 1-3, introduced a resolution requesting that "This House of Delegates strongly urge the Council on Medical Education and the specialty boards, especially those of Internal Medicine and General Surgery to move forward with the acceptance of qualified osteopathic physicians into their training programs and specialty board examinations." The resolution was adopted overwhelmingly.

Medical specialties including Internal Medicine, are thus now available to qualified osteopaths. The array of specialties now accepting DOs is changing with such rapidity that interested physicians are urged to check the standings with either the AMA or the specialty board.

This action comes close on the heels of the successful campaign by Michigan's delegation to bring about availability of full membership in the AMA itself for DOs, an action approved in June, 1969 at the AMA's Annual Meeting.

In addition to successfully sponsoring the specialty board resolution, MSMS' team of delegates and alternates, headed by Donald N. Sweeny, Jr., MD, introduced five other resolutions, all of which were favorably received and acted upon by Medicine's top policy-making body.

One of these, entitled "Discriminatory Legislation Against Professional Corporations," played a significant role in the successful stemming of an effort to roll back the pension programs of professional persons to "Keogh" contribution levels. Not only physicians and other professional men, but also their employees, can thus advantage themselves of pension programs comparable to those available to employees of business corporations.

Two Michigan resolutions dealing with professional liability insurance were favorably referred to the AMA Board of Trustees, which is engaged in an intensive continuing search for solutions to the accelerating problem of availability of professional liability coverage for physicians. Another Michigan resolution was endorsed to the AMA's Council on Health Manpower, and urged intensified efforts to develop and implement guidelines for training programs for new categories of health personnel.

Michigan's sixth resolution, unanimously adopted by the AMA House, resolved highly intensified efforts to promote environmental health throughout the United States. In this regard, the Michigan representatives took to the AMA the recent actions of MSMS' own House of Delegates, which in September resolved full support to anti-pollution programs developing in Michigan.

This report was jointly prepared by Donald N. Sweeny, Jr., M.D., Detroit, chairman, MSMS Delegation to the AMA, and by M. A. Riley, MSMS legislative counsel.

SPECIALTY SOCIETY, AMA RELATIONSHIPS

Among the paramount matters considered by the House of Delegates was the aggressive pursuit of close working relationships between the AMA and the medical specialty societies, including the coordination of Medicine's efforts in governmental relations at all levels. Recognizing that the medical profession must not become fragmented, the House has urged consideration of holding an early, major conference of specialty groups. The Dec. 15 issue of *American Medical News*, on page 9, discusses in some depth the expanded role of specialty societies as endorsed by the House, a matter of vital interest to organized medicine.

The attention of all members of MSMS is also urgently directed to the article on the same page of the same issue, explaining the establishment of a Committee on Private Practice, and setting forth the Committee's functions. Among other important charges, these include the responsibility "to assist private practitioners to improve methods of providing medical care

(Continued on Page 2)

AMA House of Delegates in Denver Acts on Six Michigan Resolutions

(Concluded from Page 1)

continually, including business practices and the efficient utilization of allied health personnel."

ABORTION-ON-DEMAND DENIED BY HOUSE

Otto K. Engelke, MD, Chairman of MSMS' Legal Affairs Committee served as chairman of one of the House's nine reference committees. His committee drew consideration of a resolution recommending repeal of all state abortion laws so that abortions would be permitted "for whatever reason." Described as a revision of policy which would make abortion available "upon demand," the resolution was soundly rejected by the House. Dr. Engelke reported that testimony in opposition to the resolution was given by over 90% of the many appearing before a packed hearing.

Instead, the AMA House determined to reaffirm its policy statement on therapeutic abortion, adopted in 1967, which would permit interruption of pregnancy for documented medical indications but would not contemplate the procedure for purely social or economic reasons.

MSMS has taken the position, with relation to proposed law changes in Michigan, that the criminal law should not apply in cases where licensed physicians perform therapeutic abortions in licensed and accredited hospitals. And were Michigan's law to be so altered, MSMS has guidelines for hospital medical staffs which conform with the AMA policy of 1967, reiterated at the 1969 Denver meeting. MSMS feels that the law may specify *who* can perform a therapeutic abortion, and *where* (in what setting) he may do so; other considerations, such as *why*, *when*, or *how* are medical judgments and not properly a part of any law on the subject.

"PEER REVIEW" GETS THOROUGH AIRING

Those attending the 1969 AMA Clinical Meeting in Denver were provided with a comprehensive, day-long meeting entirely devoted to "peer review." This meeting was reviewed in detail in the Dec. 8, 1969 issue of *American Medical News*.

Government leadership is placing heavy reliance upon all members of the medical profession to control utilization of both economic and manpower resources, an activity which requires the cooperation of many professional groups but one in which the medical profession itself occupies the most strategic position. Both the AMA and MSMS consider "peer review" to indeed be the responsibility of Medicine and feel that its importance cannot be overstated.

DOCTOR DRAFT LAW SPARKS SPIRITED DISCUSSION

Few subjects received more attention at Denver than a resolution, suggesting a modification to the doctor draft law which would permit physicians to serve in areas of identified need in lieu of military service. Representatives of the Student AMA dramatically expressed the uncertainties facing young physicians due to the draft, as well as their concern with obtaining adequate manpower in areas lacking sufficient numbers of Doctors of Medicine.

In the light of recent draft law changes, the AMA's Council on National Security is presently engaged in an all-encompassing study of current AMA policy for the purpose of developing any necessary further changes.

The relationship between the doctor draft law and the need for health services of those in areas suffering critical health manpower shortages is clearly recognized in major portions of the report on "Health Care of the Poor," prepared by a committee of the AMA Board of Trustees and adopted in Denver by the House of Delegates. The possibility of recommending a suitable amendment to the current draft laws is being analyzed as an adjunct to intensifying a volunteer physician recruitment program for areas of need, similar to the AMA Volunteer Physicians for Vietnam Program.

MICHIGAN'S DELEGATION AMONG MOST ACTIVE

Doctor Sweeny, MSMS' delegation chairman, reports that Michigan's representatives functioned in the AMA House with a high degree of effectiveness. In addition to the reference committee chairmanship of Doctor Engelke, Delegate Luther R. Leader, M.D., served as a member of the Credentials Committee and Harold F. Falls, M.D., the delegate for the Section on Ophthalmology and former Vice Speaker of the MSMS House, served on a reference committee. Each of Michigan's eight delegates and alternates monitored a specific reference committee and their presentations in the committees and on the floor of the House of Delegates resulted in approval of all matters brought forward by Michigan.

MSMAS Sets Jan. 24-25 For Seminar

The Michigan State Medical Assistants Society has planned a theme of "Communications" for its 1970 Midwinter Educational Seminar Jan. 24-25 at the Holiday Inn, Crosstown Parkway, Kalamazoo.

Three Elected To Judicial Commission

Winners of the annual selection of physicians to the MSMS Judicial Commission from Districts 1, 4 and 6 have been notified. They include: Clarence S. Livingood, M.D., Detroit, District 1; H. Maxwell Golden, M.D., Flint, District 4; C. Allen Payne, M.D., Grand Rapids, District 6.

Doctor Livingood will represent physicians in Wayne County during the coming year. Doctor Golden's constituents are physicians from Bay-Arenac-Iosco, Genesee, Gratiot-Isabella-Clare, Huron, Lapeer, Midland, Saginaw, Sanilac and Tuscola Counties. Doctor Payne represents Alpena-Alcona-Presque Isle, Chippewa-Mackinac, Delta-Schoolcraft, Dickinson-Iron, Gogebic, Grand Traverse-Leelanau-Benzie, Houghton-Baraga-Keweenaw, Luce, Manistee, Marquette-Alger, Menominee, North Central, Northern Michigan, Ontonagon and Wexford-Missaukee Counties.

The MSMS Constitution and Bylaws provide for the election of a Judicial Commission, which has general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline and professional conduct of members.

Doctor Corley Paid Tribute By Legislature

Cecil Corley, M.D., Jackson, named Michigan's Physician of the Year at the 1969 MSMS Annual Session, has been honored by a concurrent resolution of tribute from the Michigan Legislature.

The resolution, introduced in the House with the Senate concurring, offers unanimous tribute to Doctor Corley, "recognizing his merit as the Michigan Outstanding Physician of the Year and to express gratification for his many contributions to the professional and civic life in Michigan society."

1970 Maternal Health Conference March 25-26 in Flint

Plans are well underway for the Ninth Annual Michigan Conference on Maternal and Perinatal Health scheduled for March 25-26 at the Pick-Durant Hotel, Flint. Sponsors will again be MSMS and the Clara Elizabeth Fund of Flint.

General topics during the two-day meeting will include The Role of Assistants in Perinatal and Prenatal Care, Pediatrician and Nurse Aspects of the Pediatric Nurse Program, the Nurse Midwife Program – Aspects of Physician and Nurse, Respiratory Ventilation and Respiratory Distress Syndrome, Obstetrical Emergencies and Intern Care of Mother and Child.

Speakers secured so far include Burris Duncan, M.D., of the University of Colorado; Mrs. Ann Smith of the University of Colorado; J. Edward Hall, M.D., of Brooklyn, N.Y.; Paul Swyer, M.B., of Toronto; Harry Prystowsky, M.D., of Gainesville, Fla., and John P. Harm, M.D., Detroit, of the Wayne State University School of Medicine.

Chairman of the 1970 conference is Darrell E. Statzer, M.D., Detroit.

No Limits Yet Set on P.C. Pension Plans

(See Related Story, Page 58)

Professional service corporations – including those formed by physicians – have entered an apparent "period of grace" from taxation of their contributions to pension plans for stockholder employees.

Late on Dec. 9 the U.S. Senate, by a vote of 65 to 25, killed a Senate finance committee attempt to limit (to 10 per cent of income or $2,500 annually per individual stockholder, whichever is less) the lay-aside for retirement plans of professional corporations.

The action came on a floor amendment by Sen. Paul J. Fannin (R-Arizona) to delete the requirement that professional service corporations be limited to Keogh levels.

A roll call vote in the Senate revealed that Sen. Philip A. Hart of Michigan voted against Sen. Fannin's amendment to kill the Finance Committee recommendation and Sen. Robert P. Griffin of Michigan voted for the Fannin amendment.

In a telegram to Hugh W. Brenneman, executive director of MSMS, Ernest B. Howard, M.D., executive vice president of the AMA, reported that "There will be no legal restrictions this year and no legislation in the field until the Treasury Department sends recommendations to equalize the tax treatment of all pension plans following study that is not expected to be completed for many months. Congress probably will not act finally on the matter until late next year at the earliest."

The AMA and its component state societies, including MSMS, were active in the successful fight to defeat the Senate Finance Committee recommendation, as were many individual physicians who made personal contacts with their congressmen. The activities of MSMS and the AMA were also significantly augmented by other individual professionals and their state and national organizations, as well as by support from the employees of professional people and their organizations such as the Michigan State Medical Assistants Society.

C. Fred Arnold Again Leads MCCC

The Michigan Cancer Coordinating Committee will again be headed during 1970 by Mr. C. Fred Arnold, Detroit. Roscoe V. Stuber, M.D., Howell, and Helen A. Schulte of East Lansing and the MSMS staff, will continue as vice chairman and secretary, respectively.

Bernard E. Luck, DDS, of Lansing, is a new honorary member, joining Mr. Donald E. Johnson of Flint and Harry M. Nelson, M.D., of Detroit, who continue in that designation.

Representatives from various organizations to the committee are:

MSMS – Clifford W. Colwell, M.D., Flint; Daniel L. Rousseau, M.D., Mt. Clemens; Max E. Dodds, M.D., Flint, and Henry J. VandenBerg, Jr., M.D., Detroit.

Michigan Cancer Foundation – Mr. C. Fred Arnold, Detroit, and William Bromme, M.D., Detroit.

Michigan Department of Public Health – Walter F. Strempek, M.D., Lansing.

Michigan State Dental Association – Bernard E. Luck, DDS.

Michigan Health Officers Association – Byron P. Brown, M.D., Charlotte.

American Cancer Society, Michigan Division, Inc. – C. Allen Payne, M.D., Grand Rapids; Roscoe V. Stuber, M.D., Howell; Mr. Lauren S. Elliott, Flint, and Mrs. Frank C. Painter, Grass Lake.

Michigan Association of Osteopathic Physicians and Surgeons, Inc., – Norman W. Arends, D.O., Flint.

Detroit General Gets Three-Year Accreditation

The accreditation of Detroit General Hospital has been renewed for a three year period.

The director of the Board of Commissioners of the Joint Commission on Accreditation of Hospitals, Dr. John Porterfield, announced the approval in a letter to the Hospital's administrator, Alfred Plotkin.

The commissioners approved the recommendations of a survey team that visited Detroit General Hospital at the end of September. A previous inspection in 1968 had resulted in only a one year probationary accreditation. It has been the practice of the Joint Commission to grant full accreditation for a three year period. That policy will change in 1970 and full accreditation will be granted for only two year periods.

COMMITTEE CALENDAR

MSMS committees continue their busy pace of activities as the new year begins. Following is a list of their meetings for January and succeeding months:

Thursday, Jan. 8
Committee on Maternal and Perinatal Health
MSMS Headquarters
Chairman: James E. Harryman, M.D., Muskegon

Thursday, Jan. 8
Subcommittee on Perinatal and Maternal Morbidity
MSMS Headquarters
Jack R. Postle, M.D., Petoskey

Wednesday, Jan. 14
MSMS Judicial Commission
MSMS Headquarters
Chairman: Donald N. Sweeny, Jr., M.D., Detroit

Friday, Jan. 23
Committee on Mental Health
Sheraton-Cadillac Hotel, Detroit
Chairman: Benjamin Jeffries, M.D., Harper Woods

Wednesday, May 6
MSMS Committee on Cancer
MSMS Headquarters
Chairman: M. E. Dodds, M.D., Flint

Wednesday, May 6
Cancer Coordinating Committee
MSMS Headquarters
Chairman: C. Fred Arnold, Detroit

Doctor Payne

Doctor Wellman

Doctor McLean

State Board Selects Payne, McLean And Wellman

C. Allen Payne, M.D., Grand Rapids, is new president of the State Board of Registration in Medicine. A former president of the Michigan State Medical Society, Doctor Payne was elected at a Dec. 11 meeting of the State Board to succeed former president Irvin J. Kurtz, M.D., Detroit.

Also elected is Don W. McLean, M.D., Detroit, a member of the MSMS Council, to the position of vice president of the state group.

Members of the State Board unanimously chose John M. Wellman, M.D., Lansing, former chairman of the board of Michigan Blue Shield, as executive secretary of the State Board. He succeeds Luther R. Leader, M.D., Royal Oak, a past MSMS president.

DOCTOR BARTHOLOMEW ELECTED

Lee E. Bartholomew, M.D., Ann Arbor, is new president of the Michigan Rheumatism Society. He was elected at the Society's annual meeting at E. W. Sparrow Hospital, Lansing, late in November. He succeeds G. B. Bluhm, M.D., Detroit. Other new officers include Howard Duncan, M.D., Detroit, secretary-treasurer.

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

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msms leadership

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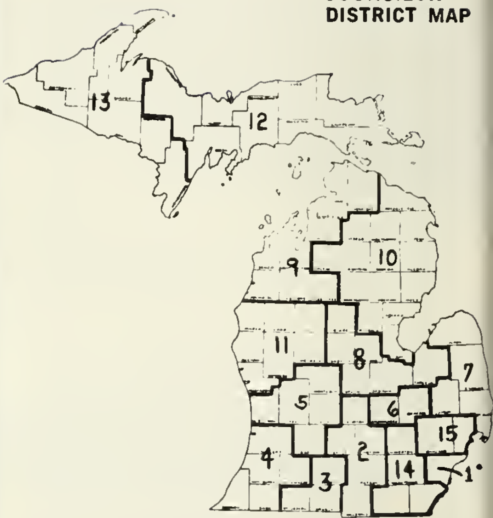
ASST. SECRETARY	Brooker L. Masters, M.D.	Fremont
TREASURER	John R. Ylvisaker, M.D.	Pontiac
ASST. TREASURER	C. Allen Payne, M.D.	Gd. Rapids
SPEAKER	James B. Blodgett, M.D.	Detroit
VICE-SPEAKER	Vernon V. Bass, M.D.	Saginaw
PAST PRESIDENT	James J. Lightbody, M.D.	Detroit
COUNCIL CHR.	Ross V. Taylor, M.D.	Jackson
VICE-CHAIRMAN	Ralph R. Cooper, M.D.	Detroit



COUNCILOR DISTRICT MAP

First District Councilors: (Wayne County)
Sidney Adler, MD, Detroit
Ralph R. Cooper, MD, Detroit
Don W. McLean, MD, Detroit
Milton R. Weed, MD, Grosse Pointe Park
Robert K. Whiteley, MD, Detroit

Second District Councilor: Ross V. Taylor, MD, Jackson
Counties: Clinton, Eaton, Hillsdale, Ingham, Jackson
Third District Councilor: Robert M. Leitch, MD, Union City
Counties: Branch, Calhoun, St. Joseph
Fourth District Councilor: Don Marshall, MD, Kalamazoo
Counties: Allegan, Berrien, Cass, Kalamazoo, Van Buren
Fifth District Councilor: John R. Pedden, MD, Grand Rapids
Counties: Barry, Ionia-Montcalm, Kent, Ottawa
Sixth District Councilor: Ernest P. Griffin, Jr., MD, Flint
Counties: Genesee, Shiawassee
Seventh District Councilor: John J. Coury, MD, Port Huron
Counties: Huron, Sanilac, Lapeer, St. Clair
Eighth District Councilor: A. Carl Stander, MD, Saginaw
Counties: Gratiot-Isabella-Clare, Midland, Saginaw, Tuscola
Ninth District Councilor: Adam C. McClay, MD, Traverse City
Counties: Grand Traverse-Leelanau-Benzie, Manistee, Northern Michigan (Antrim, Charlevoix, Cheboygan and Emmet combined), Wexford-Missaukee
Tenth District Councilor: Robert C. Prophater, MD, Bay City
Counties: Alpena-Alcona-Presque Isle, Bay-Arenac-Iosco, North Central Counties (Otsego, Montmorency, Crawford, Oscoda, Roscommon, Ogemaw, Gladwin and Kalkaska, combined)
Eleventh District Councilor: Brooker L. Masters, MD, Fremont
Counties: Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana
Twelfth District Councilor: William A. LeMire, Sr., MD, Escanaba
Counties: Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger
Thirteenth District Councilor: J. Robert Franck, Jr., MD, Wakefield
Counties: Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon
Fourteenth District Councilor: Harold F. Falls, MD, Ann Arbor
Counties: Lenawee, Livingston, Monroe, Washtenaw
Fifteenth District Councilor: Sydney Scher, MD, Mount Clemens
Counties: Macomb, Oakland

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Lester P. Dodd.................Detroit
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Clyde T. Hardwick............Detroit
HISTORIAN
Wm. J. Stapleton, Jr., MD......Detroit
ASS'T HISTORIAN
Wm. M. LeFevre, MD........Muskegon

The Price . . . The Values

As I visit with physicians across the state, occasionally some doctor will say:

"Well, medical organization work is fine for you and some others like you, but not for me — I just believe in taking care of my patients."

How nearsighted can a person be? How can we be isolated from medical organizational efforts and still practice with our customary freedom? We can't. Medical freedoms remain only for those who fight for them.

MEDICAL ORGANIZATIONAL work cannot be done alone by me, or by the other officers and members of The MSMS Council. Or by the members of the MSMS House of Delegates. Or by our delegates to the AMA House of Delegates. Or by the officers of the county medical societies. Or only by those physicians who serve in responsible positions in health planning groups, on hospital staffs and boards, on civic bodies, etc.

Every member of MSMS must attend his county medical society meetings, must participate in studies and projects that advance our concerns, etc., etc.

And to what end?

THESE ARE SOME of the values that we receive from medical organization work:

- Medical organizations set professional standards of medical care and provide yardsticks to measure them . . .

- Medical organizations provide means of controlling costs of professional medical care . . .

- Medical organizations fight for a climate of professional freedom in which we can practice . . .

- Medical organizations prescribe minimum standards for medical education . . .

- Medical organizations speak out for more dollars to train more doctors and medical associates . . .

- Medical organizations today are aware of new demands, new conditions, changing relationships, etc. Committees study new problems, boards and councils adopt new projects, etc.

THE PRICE FOR MEDICAL organizations and what they accomplish every day for each of us is the effort that we must expend to make our organization even more pertinent to the changing needs of the day.

The job of the medical organizations is the job for every physician. Apathetic, disinterested members lead only to weak, ineffective organizations. Informed, motivated, interested doctors can — and do — make the contributions that must be made today and tomorrow to build even greater medical organizations.

PRESIDENT MASON

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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(meprobamate)

Wyeth®

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Photo professionally posed.

He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300 b.i.d.

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

IN THIS ISSUE

SCIENTIFIC ARTICLES

15 Medicare in Michigan; Beverly C. Payne, M.D.
23 Abortion Law Reform Progress in Michigan; Jack M. Stack, M.D.
29 Problems Resulting from Suppressible and Nonsuppressible Thyroid Function; Donald A. Meier, M.D.; Joel I. Hamburger, M.D.
33 Pulmonary Hypertension—A Complication of Aortic Valve Disease; Marvin M. Kirsch, M.D.; Thomas Orvald, M.D.; Thomas Preston, M.D.; Donald Kahn, M.D.

SPECIAL ARTICLES

56 Michigan Blue Shield Charges Muskegon Study "Prejudiced"; Neal McCue
58 The Question of Incorporating; Judith Marr
80 Michigan Communities Need Physicians

OTHER FEATURES

1 breaking news
6 leadership page
7 officers' page
12 your opinion, please
13 medico-legal
22 monthly surveillance report
22 Drug Therapy Problems
41 msms news
michigan mediscene
44 extract of MSMS Council Minutes
52 editorial viewpoints
65 county societies
74 about doctors
76 welcome
84 in memoriam
88 noted and quoted

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MICHIGAN

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your opinion please

What are your reactions regarding the views of some that the medical profession should direct the location of physicians in order to help alleviate health manpower shortages in certain areas and in order to prevent MD-oversupply in some other areas?

Donald K. Barstow, M.D.
Engadine

It is, first, unrealistic to believe that the profession or anyone else could tell a physician where he must practice. There are many factors aside from medicine that lead to this decision.

Secondly, many areas short of physicians are also short of medical facilities, population, and the economic base necessary to attend them.

Possibly some general subsidation of physicians and/or facilities might help to improve the situation.

Paul J. Connolly, M.D.
Detroit

If we lived in a totalitarian nation doctors could be ordered to practice in districts where the need is greatest. Another method of solving such situations would be to require a two-year period of practicing in areas in need of physicians, for all doctors, after completion of their intern training. This would be similar to the present use of doctors in the military service. Neither of these methods fits in with the freedom that we enjoy in this nation and the price that we would have to pay in ordering doctors into such areas is much higher than the value to be derived. Therefore, we must look to other means to get doctors to voluntarily correct the mal-distribution of physicians that exist at the present time.

While the medical profession should be active in locating and supplementing these methods, it will take the help of communities, local governments, and many lay people in addition to the medical profession itself. The federal government has already helped by making it financially feasible to practice in substandard areas, this is by making payments to the doctor by means of Medicare and Medicaid. Established doctors may find that they can help their communities by giving a few hours each week to work in one of these areas.

First, however, the community must have set up the physical plant and necessary equipment and recruited the ancillary lay personnel, which is essential for success of the project. The young man starting in practice may also find that he could develop part of his practice in a depressed area. He would be performing a community service, while still receiving enough financial remuneration to sustain him while he is becoming established.

I think our efforts should be directed to making practice more rewarding in the understaffed areas of the country and in doing so, we must work with all of the facilities available to us, especially, the help available in the involved community.

Victor A. Notier, M.D.
Grand Rapids

My reactions regarding the location of physicians vary depending on how one interprets the word "direct." If this means a compulsory location, I am totally against such a view. It is unthinkable that a profession that has always maintained the concept of "freedom of practice" and "a free choice of physician by the patient," should now suggest taking away the choice by the physician to serve where he pleases.

I feel that the medical profession should help a physician find a location in an area that needs health manpower. We have pledged ourselves to the service of humanity, which I feel is collective as well as individual.

There are multiple reasons why certain areas lack health manpower. One is the numerical lack of physicians trained in general practice. Another is the inadequate compensation for his total service to the community, a service which is demanding and overwhelming in expenditure of time and energy. A third reason is the realization that a physician may also be a husband and a father, and is concerned with the welfare, education, happiness and living conditions of his family as well as himself.

The medical profession, therefore, can and should help by encouraging physicians to locate in areas where they are most needed. This can be expedited by working with the people of the area, in creating "job offers," or compensation for his services, or fringe benefits of a nature that would entice a physician to locate in these areas.

Whatever method we use to help locate a physician, or for whatever reason he may accept this location, let it be on a voluntary basis and never directed.

Ahmad Younis, M.D.
Greenville

I am in favor of the active participation of the medical profession in alleviating health manpower shortages in certain areas. The following could be done:

1. To compile the necessary data about each region and include not only the advantages of that particular location but also its disadvantages and make it available to all medical students.

2. Medical schools should be contacted and made agreeable to encourage medical students to specialize in family or general practice.

3. Specialists, instead of concentrating around big urban areas, should be encouraged to locate in a central location to be able to cover the needs of several communities and general practitioners.

4. Increase the number of medical graduates through the establishment of new medical schools or the enlargement of the capacities of the existing medical schools.

As long as we in this country believe in free enterprise and that we can in no way legislate or dictate policies to a group like ours, I feel the key to this problem is incentive. This incentive could be offered in many ways. I can think of two.

1. Financial assistance or scholarship to medical students who would agree to locate in such areas as general practitioners whether this should be offered by the medical profession or possibly by the locale through the Chamber of Commerce.

2. A loan for starting physicians to establish a practice without undue financial burden in their first few years

What's Your Evaluation Of Peer Review?

"Your Opinion Please" is a new monthly feature in *Michigan Medicine* so we can print the views of more Michigan physicians on vital issues. Your comments are invited in response to the question asked on this page.

A question will be selected each month and interested physicians are urged to send in their reactions. Letters in response to the question for the March issue must be received in the MSMS office by February 1.

The March question will be:

"Do you believe the medical profession is successfully meeting its professional obligations in the area of peer review, and if not how could the profession improve its leadership in this field?"

— Brooker L. Masters, M.D.
Chairman
Publication Committee

EVIDENCE FAILS TO SHOW INFECTION CAUSED BY HOSPITAL'S NEGLIGENCE

(Editor's Note: The following article is quoted from the AMA Citation newsletter of Nov. 1, 1969, prepared by the AMA Law Department.)

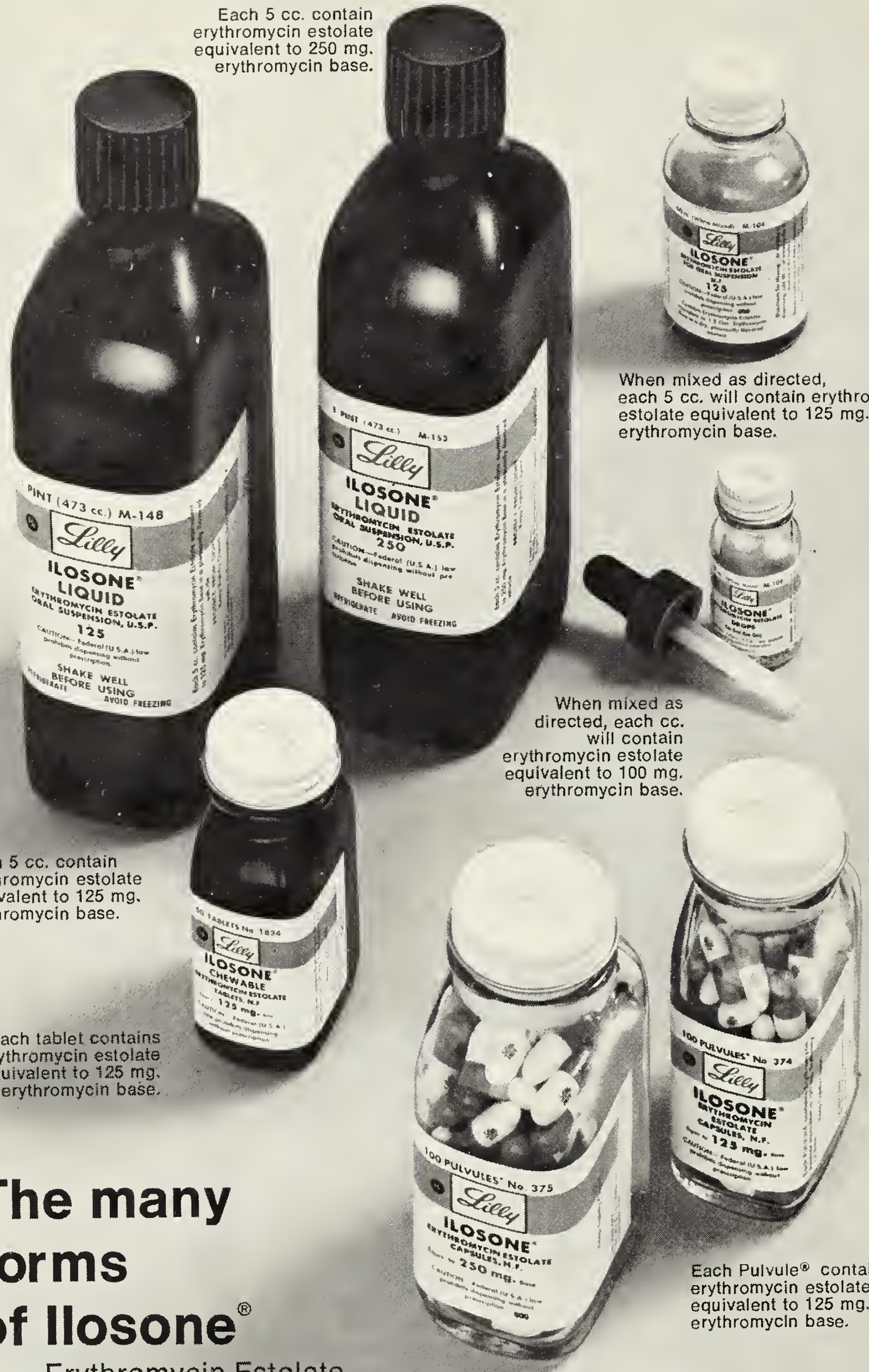
A hospital was held not liable in a suit by a patient who developed a staph infection, allegedly as a result of a nurse's negligent administration of an injection. The patient relied on the doctrine of *res ipsa loquitur*. However, because there was no evidence from which the jury could reasonably infer that the infection was caused by negligence, the appellate court upheld a reversal by the trial judge of the jury's verdict for the patient.

The woman was given a shot in May, and the next day her arm swelled in the area in which the infection first occurred. During June, she was in and out of the hospital for the birth of a child and for eczema treatments. She did not complain about her arm. Hospital records indicated that on June 25 her arm had a sterile abscess with no suppuration. On June 29, the infection allegedly erupted on her arm.

Her own physician testified that, in his opinion, the staph infection was not caused by the injection, that there were many ways it could have entered the bloodstream, and that her scratching, due to eczema, could have made her more susceptible to infection. Evidence also showed that her husband had been near persons who had the infection prior to the time she developed it.

The nurse said that she used the standard procedure in giving the shot. The occurrence of an infection is not enough to imply negligence, the court said; one can only speculate that the staph was a result of negligence.—*Rhody* v. *James Decker Munson Hospital,* 170 N.W.2d 67 (Mich., May 29, 1969)

From Vol. 20, No. 2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Medicare in Michigan

BY BEVERLY C. PAYNE, M.D.
ANN ARBOR

Much speculation and many forecasts have been made about the impact of Medicare legislation on the delivery of medical care. Implemented in July, 1966 it is well to examine, even at this early interval, what precisely *has* occurred in measureable degree. The subjective measures I have taken from my own and my colleagues' experience, the objective measures were obtained from Michigan Medical Service, Michigan Hospital Service, correspondence with state professional organizations, and refined data from 76 Michigan hospitals which participate in the Professional Activity Study.

As a practicing internist my subjective evaluations begin with the recognition of a change in relationship with my elderly patients. I now bill my over-65-year-old patient the usual and customary fees charged the remainder of my patients and the over-65-year-old patient is reimbursed by the Medicare intermediary. Occasionally, at the request of the patient, I accept an assignment of benefits as the regulations provide. One problem unwittingly produced by the provision of "assignment" is that the patient fails to recognize his obligation to pay the $50 deductible and the 20% co-insurance. He assumes that by directing the fiscal intermediary to pay the physician directly he is somehow relieved of this personal obligation. It is a misunderstanding, but it takes a lot of explanation and time and abraded feelings before the problem is resolved.

THIS MATTER of explanation of benefits to elderly patients has proven a real problem for the office staff and the physician as well. The social security office does a very poor job of clarifying the patient's responsibilities and benefits. The patient, because of the dependent nature of his relationship with his physician, eventually expects a satisfactory solution to come from his doctor. Who can deny him this expectation? Pamphlets, completion of forms, normal billing procedures, and conversational instruction all are used in educating the patient. Most patients grasp the procedures to be followed easily, but for the senile or confused patient, compliance with the procedures requires an indoctrination of his responsible family or friend. Even in well-established friendly relations there has come, briefly I hope, a suspicion that the implementation of the regulations of Medicare are manipulated by the physician to his advantage.

THE INITIAL angry frustration of physician and patient with bureaucratic delays in payment by the fiscal intermediary have recently given way to satisfaction with an interval of one month or less from billing to payment. Problems still remain, but apparently Blue Shield is now sufficiently versatile and rapid to produce prompt payment of benefits; and physicians and patients are producing suitable evidence of the service benefit claimed.

That there are more forms, more clerical time, and more billing procedures is undeniable, but there are also positive effects. The elderly are no longer reluctant to get necessary laboratory studies or to be hospitalized because of the financial burden on a fixed income, or on their family's income. Conversely, I have little evidence to suggest that there is any increased pressure on physicians to perform examinations or to hospitalize the elderly unnecessarily. Similarly, there is no evidence that the necessity for three days' hospitalization before transfer to an extended care facility has increased these "Medicare admissions." We will examine this statistically later.

THE BENEFITS provided for extended care facilities have focused sharply on the lack of such physical facilities in Michigan and the very real need for nursing home care for the elderly. In November, 1967 there were 8,634 extended care facility beds for Medicare recipients and 20,878 nursing home beds.[1] This shadowy land of distinction between the extended care facility benefit and the custodial care nursing home which is not a benefit has caused much stress, resentment, and frustration on the part of the families of

scientific papers

Prepared for presentation September 26, 1968 to the Annual Session of Michigan State Medical Society, Section on Public Health and Preventive Medicine, Detroit, Michigan.

The author is an internist with St. Joseph Mercy Hospital, Ann Arbor, and assistant dean of the School of Medicine, The University of Michigan.

TABLE I

TOTAL, WHITE, AND BLACK DISCHARGES FROM 76 P.A.S. GENERAL HOSPITALS IN MICHIGAN
1965 - 1967

(changes based on 1965)

	TOTAL PATIENTS			WHITE PATIENTS			BLACK PATIENTS		
	Number of Patients	Change in No. and %		Number of Patients	Change in No. and %		Number of Patients	Change in No. and %	
All Patients									
1965	197, 146	-1439	-0.7	181, 335	-3031	-1.67	12, 136	+842	+6.93
1967	195, 707			178, 304			12, 978		
65 and Over									
1965	34, 621	+4145	+12	33, 005	+3832	+11.6	1, 041	+394	+37.8
1967	38, 766			36, 837			1, 435		
64 and Less									
1965	162, 525	-5584	-3.4	148, 330	-6863	-4.6	11, 095	+448	+4.0
1967	156, 941			141, 467			11, 543<		

Medicare beneficiaries and a professionally unacceptable decision on the part of the physician.

The reaction of professional societies to the realities of the Medicare regulations has generally been to accept no assignments and to bill the patient directly for services[2] and assist him in the process of reimbursement from the fiscal intermediary. The actual performance indicates, however, that of 272 Michigan hospitals 213 of them bill the Medicare intermediary directly for radiologic services and in only 59 do the radiologists bill separately for their services. Over 90% of pathologist services are billed to the fiscal intermediary by the hospital. In June, 1968, Blue Shield reported that 61.2% of the dollar disbursements under Medicare went to the providers (i.e., by assignment of benefit to physician or hospital) and 38.8% to recipients of Medicare care.

THE REPLACEMENT of the M-75 program of Blue Shield (with fees related to income at schedules A, B, C, and D) by a reasonable, customary, and prevailing fee structure has occasioned a varied reaction among physicians. First was a crisis of confidence in Blue Shield — a disbelief among physicians that Blue Shield was implementing the program as described and secondly a feeling that the "prevailing" concept was more important than the "usual and customary" with a consequent leveling of fees.

In reviewing the charges made by Michigan physicians to the Medicare intermediary it is apparent that there has been a leveling of charges — upward.

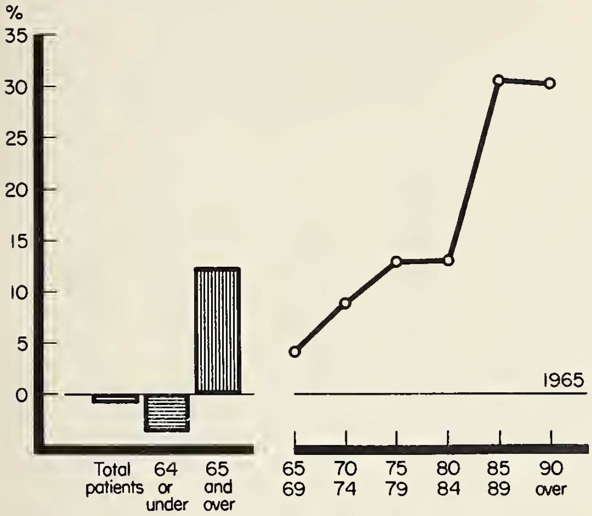
Blue Shield, as the fiscal intermediary, announced that its concept of "usual, customary, and prevailing" fees or charges would be related to or based upon the published recommendations of the Michigan State Medical Society in the Michigan Relative Value Study. This study recommendation was the fruit of several years of tireless effort by a committee of the M.S.M.S. and has received the acceptance of the Society through its House of Delegates. The study recommends a "relative value" for medical and surgical procedures in units. This coupled with a recommended dollar value for each unit is then converted to a fee or charge.

COMPARISON OF the actual average charges by physicians between December, 1966 and June, 1968 demonstrates an increase of 11.8%.[3] However, it was acknowledged by Blue Shield that the baseline observation for charges in 1965 was artificially depressed by the existing method of physician reimbursement under the M-75 contracts. Correcting this baseline observation to an adjusted average charge in December, 1966 based on the Michigan Relative Value Study (with a unit conversion factor of $5.00) reveals that an increase in average charges in 1967 was 8.3%. The 3.5% difference between the two methods of computation could then be accepted as an adjustment of the baseline in 1966 to the same basis of computation of the 1968 average charges.

Within this 8.3% increase the separate medical specialties record different rates of increase. The average in-hospital surgical charges rose 10% above the MRVS base in December 1966. Medical charges in hospitals were 21% below the base in 1966 and rose 12% by June, 1968, still 9% below the baseline. Home and office physician visits were 11% above the base in 1966 and rose 7% in 1968.

GRAPH A

CHANGE IN TOTAL DISCHARGED PATIENTS BY AGE GROUPS BETWEEN JULY-DECEMBER 1965-1967 (FROM 76 P.A.S. GENERAL HOSPITALS IN MICHIGAN)



In order to quantify the impact of Medicare legislation on Michigan hospitals and medical staffs a statistical base was sought. I obtained from the Commission on Professional and Hospital Activities in Ann Arbor such statistical data developed from 76 Michigan hospitals in two time periods: from July 1 to December 31, 1965, and July 1 to December 31, 1967. These two six-month periods precede and follow the actual beginning date of Medicare benefits as of July 1, 1966.

These *76* hospitals are a group of Michigan hospitals voluntarily associating with the Commission on Professional and Hospital Activity out of a total of *148* non-governmental, non-profit, short-term general hospitals in Michigan. These 76 hospitals discharged 195,707 patients of the 428,308 patients admitted to all 148 hospitals in Michigan in 1967. The sample thus represents slightly more than half of the hospitals providing short-term general care and about 45% of the patients cared for in these hospitals in Michigan. All 76 hospitals are certified as participants in Medicare as of July 1966 by the Michigan Department of Public Health.

The hospitals were divided into five categories by annual number of discharges (which roughly approximates their size in terms of beds) as follows: 1) *Very Small Hospitals* (15 in number) less than 2,500 discharges per year, 2) *Small Hospitals* (21 in number) 2,500-4,999 discharges per year, 3) *Medium Small Hospitals* (17 in number) 5,000-9,999 discharges per year, 4) *Medium Large Hospitals* (13 in number) 10,000-14,999 discharges per year, 5) *Large Hospitals* (10 in number) 15,000 discharges or more per year.

All of the data exclude maternity and newborn patients except in the calculations of hospital occupancy rates.

DISCHARGE STATISTICS

In these 76 hospitals between the two time periods studied (1965-1967) there was a decrease in the total number of patients discharged. This decrease meant that 1,439 fewer patients were cared for in 1967 compared to 1965 in a six-month period. This decrease in total number of patients discharged was due to 5,584 fewer patients 64 years or under, a decline of 3.4%. There was a converse increase by 4,145 discharges in the 65 and over age group, an increase of 12%. The overall decrease was 0.7% in discharges from all hospitals in all age groups. **(Table I)**

In all patients over the age of 65 years an examination of the 5 year age groups demonstrates a progressive increase in percentage of discharges with advancing age. **(Graph A)**

MEDICARE LEGISLATION was expected to provide medical care for a deprived group of our citizens — not only over 65 but black as well. Examination of the racial origin of these discharged patients indicates that there is an overall decrease in white patient discharges and a converse increase in black patient discharges (see **Table I**). In the over-65 group there is an 11.6% increase in white patient discharges compared with a 37.8% increase in black patient discharges. Under age 65 the white patient discharges actually decreased while the black patient discharges in this same age group increased. This decrease in under-65 patients is not related to Medicare legislation directly but perhaps indirectly by displacement of the younger patient by the elderly in competition for scarce hospital bed days.

LENGTH OF STAY

The average length of stay increased for the 64-years and under group only 0.1 day while the 65 and over group stayed 1.2 days longer than before. The average length of stay for the young patient (under 65) demonstrates an orderly progression related to hospital size, being briefest in the small hospital (6.4 days) and longest in the large hospital (7.6 days). There was no significant change in this pattern between the two study years. **(Table II A & B)**

The average length of stay for the elderly patient shows virtually no change in the smallest hospital and the largest hospital group. However, there is a significant increase in length of stay in the small, medium small, and medium large hospital group averaging 1.9 days with most of this increase in the small and medium small hospitals.

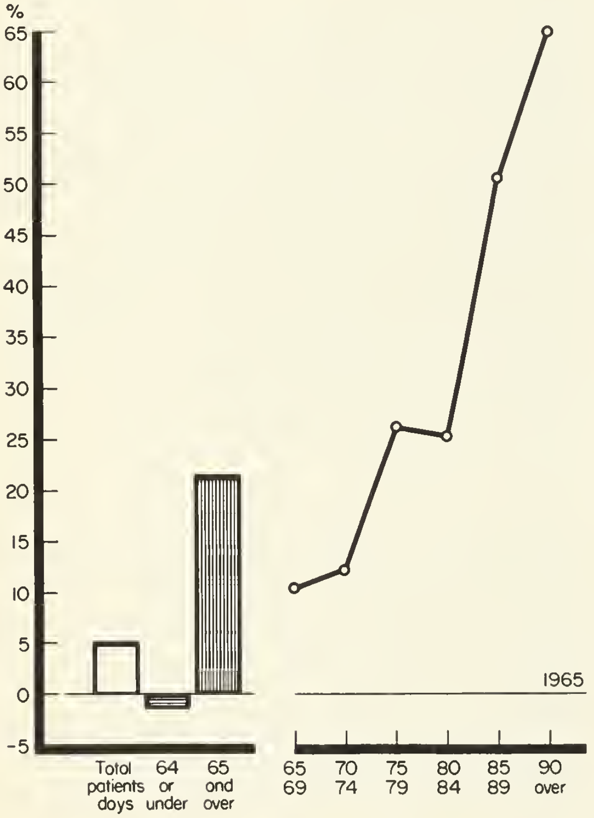
TABLE IIA

TOTAL PATIENTS, PERCENT DAYS OF STAY, AND LENGTH OF STAY BY AGE GROUPS IN VARIOUS SIZED MICHIGAN HOSPITALS July-December 1965

	65/over 3 day Stay	% Day Stay 65/over	64/under Av. Length of Stay	65/over Av. Length of Stay
All 76 Hospitals	17.7%	28.9%	7.3	13.9
Small −2500	20.8%	40.9%	6.4	14.5
Small +2500	20.6%	36.5%	6.9	14.1
Medium Small	25.7%	29.9%	7.0	14.6
Medium Large	18.7%	26.3%	7.5	13.7
Large	13.8%	25.6%	7.6	13.5

GRAPH B

CHANGE IN PATIENT DAYS OF STAY BY AGE GROUPS BETWEEN JULY-DECEMBER 1965-1967 (FROM 76 P.A.S. GENERAL HOSPITALS IN MICHIGAN)



Such deviations are not readily explained with the existing data.

TABLE IIB

TOTAL PATIENTS, PERCENT DAYS OF STAY, AND LENGTH OF STAY BY AGE GROUPS IN VARIOUS SIZED MICHIGAN HOSPITALS July-December 1967

	65/over 3 day Stay	% Day Stay 65/over	64/under Av. Length of Stay	65/over Av. Length of Stay
All 76 Hospitals	15.0%	33.5%	7.4	15.1
Small −2500	20.6%	47.0%	6.8	14.7
Small +2500	15.4%	42.4%	7.1	16.7
Medium Small	15.8%	32.2%	7.3	16.9
Medium Large	14.2%	28.9%	7.5	14.7
Large	13.5%	29.7%	7.6	13.8

MEDICARE REGULATIONS provide for a 3-day stay in the general hospital immediately preceding admission to an extended care facility. It might be expected that we find an increase frequency of 3-day admissions between the 2 study years. This was not the case, just the converse occurred, and there was a decrease of almost 3% in 3-day stays between 1965 and 1967. This does not appear to be significant. (Table II A & B)

White patients in this older group stayed an average of 1.1 days longer in 1967 and black patients only 0.2 days longer. The length of stay in the elderly is almost directly related to the age of the patient and irregularly increases with each five-year period.

Black patients over 65 stayed in the hospital 16.3 days on the average in 1967. White patients over 65 years stayed in the hospital 15 days on the average in 1967.

Within the 5 year age groups of elderly white patients there is confirmation of evidence already stated for all patients, i.e., of an unsteady progression of length of stay for each 5 year age break.

There are insufficient numbers of black patients in the 5 year age group break over age 65 years to make any certain observation, however, there appears to be no increase in length of stay with years beyond 65-69 and an actual decrease in the group age 85 and beyond.

PATIENT DAYS OF STAY

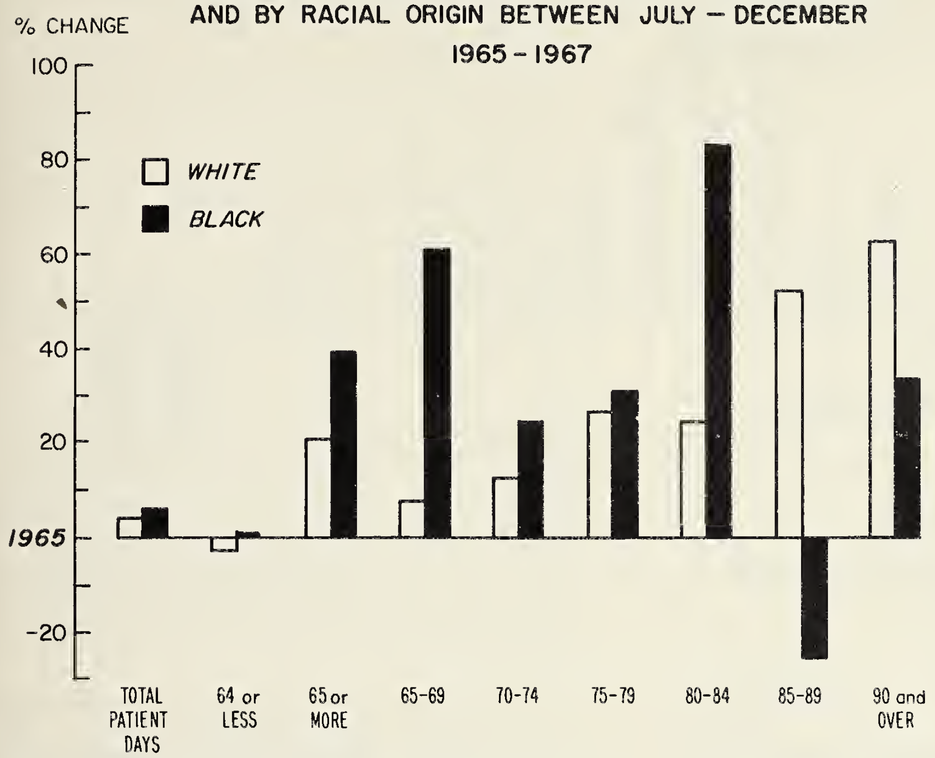
The most meaningful measure of hospital use is by the patient days of stay, i.e., the number of patients times the average length of stay.

In 1965 28.9% of patient days of stay were by patients over 65 years and 71.1% under 65 years. This relationship *does* vary considerably with hospital size. In very small hospitals the elderly account for 40.9% of patient days stay and the under 65 for 59.1%. In large hospitals this proportion is 25.6% elderly and 74.4% under 65 years.

In 1967 these relative proportions shift with an increase in all hospitals and in each group of hospitals of the elderly patient days stay. In the

GRAPH C

CHANGE IN PATIENTS DAYS OF STAY BY AGE GROUP AND BY RACIAL ORIGIN BETWEEN JULY – DECEMBER 1965 - 1967



total hospitals (76) this relationship was 33.5% over 65 and 66.5% under 65 years of age.

Patients under 65 used *less* days of stay and patients over 65 used *more* days of stay between the two six-month study periods. For all patients there is a steady increase in patient bed days in each 5 year age group above 65 years. **(Graph B)**

The patient days of stay can further be analyzed for those over the magic age of 65 by racial origin. In **Graph C** there is represented a steady increase in days of stay for black and white patients in each 5 year grouping above age 65.

There was a proportionately larger increase in the elderly black patient days of stay between 1965-1967 when compared with the elderly white patient increase days of stay. **(Graph C)**

When examined by hospital size the patient bed days demonstrate the largest proportional increase of elderly in the small hospitals. In all size hospitals the younger patient has a decreased number of bed days while we see an increase in patient days of stay for the over 65 age group.

OCCUPANCY RATE

The hospitals by size and in total experienced an increase in total occupancy rate of 2% to 5%. The largest hospitals now are confronted with the problems attendent on an occupancy rate of almost 90%.

The rate of occupancy rose most sharply (5%) in the small (+2500 discharges) and the medium small hospitals and least in the smallest and largest hospitals (2-3%).

OPERATION FREQUENCY DATA

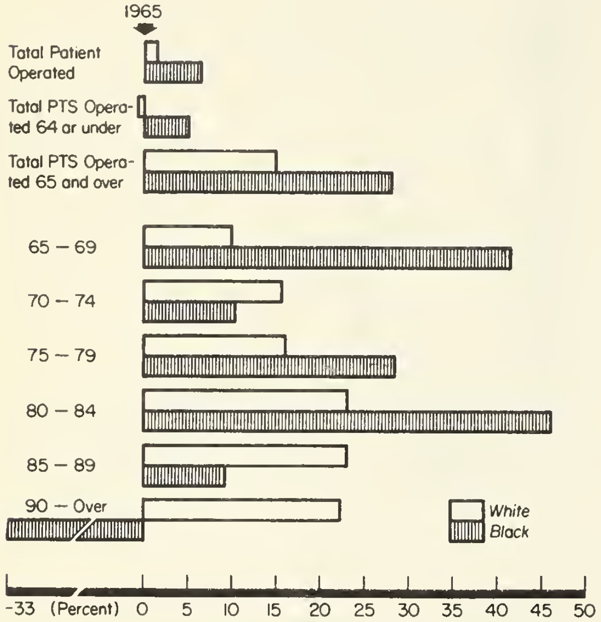
Total patients over age 65 with original operations increased by *14.6%* in 1967. Recall that there was an increase, in total patients over age 65 discharged, of 12% in 1967. There was an increase of only *0.6%* in operative procedures in the under 65 group in 1967. The greatest increase in operative days stay occurred in the medium small and large hospitals. Again, the black patient percent of increase was greater than white, but the number of black patients was small. **(Graph D)**

When specific operative procedures in the 65+ age group are examined we find a minor increase in cholecystectomy, and a modest increase in hemorrhoidectomy, and hernia repair, while the frequency of these procedures in the 64 and under age group remain fairly stable. The increase in cataract surgery is essentially the same for both age groups, apparently unaffected by the advent of Medicare. A minor increase in repair of cystocele and/or rectocele is seen in the over-65 group, four cases only, and a simultaneous decrease in the 64 and under group. **(Graph E)** The individual surgical procedures studied account for only 0.2% of the increase in surgical procedures between 1965-1967.

Referring to **Graph F** and the relative changes

GRAPH D

PERCENTAGE OF CHANGE IN FREQUENCY OF ALL OPERATIVE PROCEDURES BY AGE GROUP AND BY RACIAL ORIGIN BETWEEN JULY-DECEMBER 1965-1967 (76 P.A.S. GENERAL HOSPITALS IN MICHIGAN)



in use of laboratory, radiologic, and therapeutic aids we record all the changes related to the 21% *increase* in total days stay. For this 21% *more* days stay there were 23% more consultations and 180% more transfusions. There were 44% *less* B.M.R. determinations and virtually all survey chest X-rays were discontinued with a corresponding increase in full size chest X-rays of 76%. These two observations can be considered technologic changes. Electroencephalograms, radioactive tracers, and serum electrolytes showed the most remarkable increase with all the other variables increasing generally, from 20% to 40%.

COMMENT

In summary, the following facts were ascertained as comparisons between 1965 and 1967 in 76 Michigan hospitals:

1. There has been an increase in total number of patients over 65 in the hospital (12%) and an increase in total days of stay (21%) coupled with an increasing average length of stay of 1.2 days for those over age 65.

2. There is a slight decrease in the total number of patients under 65 years of age in the hospital and they stay approximately the same length of time in the hospital as before.

3. There were 1,439 fewer patients discharged from the 76 hospitals between 1965 and 1967.

4. Negro patients entered the hospital with an increasing frequency, and had a higher rate of increase than whites in discharges and operative procedures. The average length of stay for Negro patients is significantly greater than for the white patient.

5. There is no percentage increase of frequency of 3 days hospital stays since Medicare began.

6. Bed occupancy has risen 3% to 5% since advent of Medicare to nearly 90% in large hospitals in 1967.

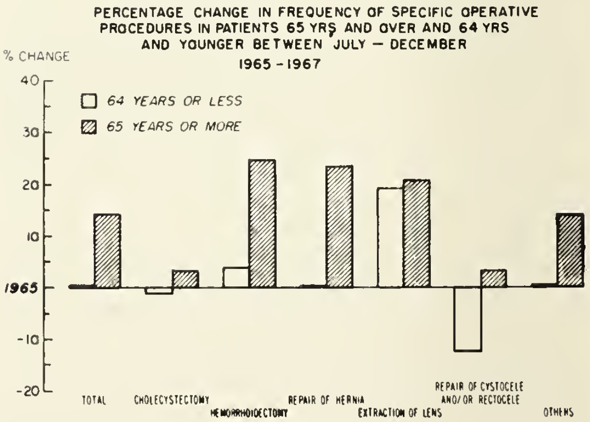
7. Radiologic, laboratory, therapeutic, and consultation services rendered to elderly patients increased substantially between 1965 and 1967.

8. There has been an irregular increase in operative procedures in the elderly since advent of Medicare (14.6%) slightly exceeding the percentage of increase in total elderly patients discharged (12%). However, by individual diagnosis the increase in elective surgical procedures does not seem extraordinary and in some instances (cataracts) has increased no more than those procedures in the 64 year old or less population.

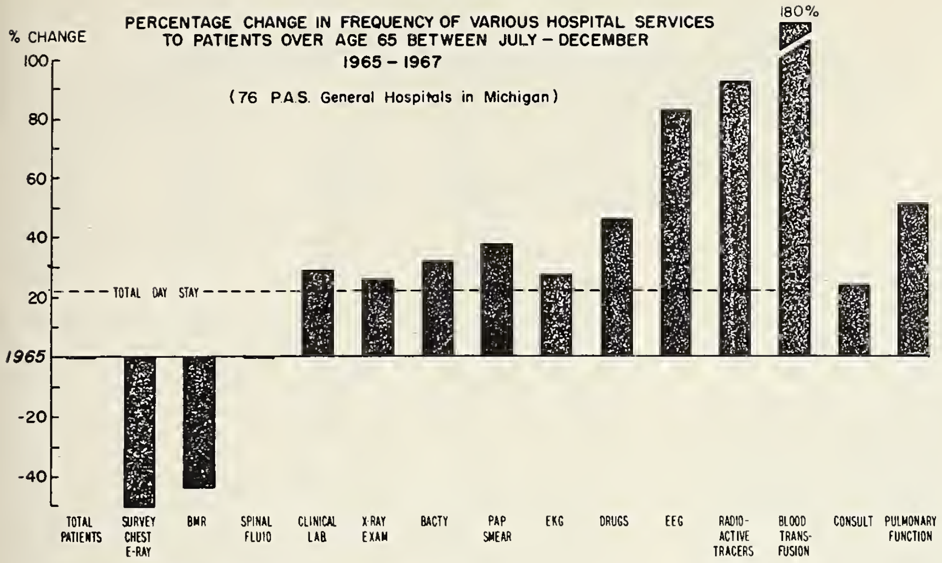
9. Services by the radiologist and pathologist are generally billed through the fiscal intermediary, and approximately 61% of all disbursements by the intermediary went directly to the providers of care.

10. According to the consumer price index calculations of fee variations throughout the nation, covering the same period of time for which we have comparable data for Michigan, there is an 8.7% increase in consumer price index for all services. Against this background dental fees have risen 9.8% between December 1966 and June 1968, and physicians' fees have risen 12%.[4] Michigan physicians' fees increased 11.8% during this same period as measured by Michigan Medical Service. Dental fees, of course, are not covered by Medicare.

GRAPH E


PERCENTAGE CHANGE IN FREQUENCY OF SPECIFIC OPERATIVE PROCEDURES IN PATIENTS 65 YRS AND OVER AND 64 YRS AND YOUNGER BETWEEN JULY – DECEMBER 1965 - 1967

GRAPH F



Clinical Laboratory Tests include the following: Urinalysis, blood sugar, electrolytes, nitrogen derivatives, liver-function tests, prothrombin time.

X-ray Exam includes: Chest x-ray, skeletal, gall bladder, gastrointestinal, urogenital, cardiovascular.

Bacteriology includes: Smear, culture, antibiogram.

Drugs include: Antibiotics, anticoagulants, cardiac regulatory, oxygen, hormone.

SUMMARY

The system of hospital and medical care financing introduced by Medicare legislation to become effective in July, 1966 has created discernible but not dislocating changes in the delivery of these health care services. It has produced a stable source of financing care for the over 65 year group of patients and this is reflected in the greater number and range of services available to and received by them after the introduction of Medicare.

ACKNOWLEDGEMENT

The vital assistance of Avedis Donabedian, M.D., in preparation of this paper is gratefully recognized. The technical assistance of Sang Rhee in processing the data is also greatly appreciated.

Additional tables are available on request from the author.

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2. (a) Personal communication from William D. Cheney, M.D., President Detroit Roentgen Ray Society, July 25, 1968.
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Monthly Surveillance Report
Cases of Certain Diseases Reported To The Michigan Department of Public Health For The Five-Week Period Ending November 28, 1969

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1969 THIS 5-WEEK PERIOD	1968 SAME 5-WEEK PERIOD	1969 TOTAL TO ABOVE DATE	1968 TOTAL SAME DATE	TOTAL CASES FOR 1968
Rubella	172	153	4092	1780	1953
Measles	42	22	355	313	352
Whooping Cough	16	30	168	405	429
Diphtheria	—	—	—	—	—
Mumps	528	650	4698	14029	14655
Scarlet Fever & Strep Sore Throat	1076	945	8384	8970	10101
Tetanus	1	—	5	3	5
Poliomyelitis (Paralytic)	—	2	—	3	3
Hepatitis	413	267	3017	2071	2356
Salmonellosis (Other than S. typhi)	60	47	499	566	614
Typhoid Fever (S. typhi)	1	—	6	—	1
Shigellosis	42	35	285	281	346
Aseptic Meningitis	33	23	169	247	265
Encephaltis	8	14	113	95	114
Meningococcic Meningitis	8	9	103	84	94
H. Influenzal Meningitis	5	10	50	57	64
Tuberculosis	184	187	1948	2509	2647
Syphilis	360	542	3779	5019	5351
Gonorrhea	1907	1855	17610	16768	18153

Information can be supplied by the local health department on the local incidence of disease.

Drug Therapy Problems

Interested Michigan physicians are invited to direct any questions they may have on drugs and their use to the authors of this new column, appearing for the first time in MICHIGAN MEDICINE. Requests for information should be mailed to Robert E. Pearson, M.S., and Fred J. Salter, Pharm.D., Michigan Regional Drug Information Center, Hospital Pharmacy, University Hospital, Ann Arbor, 48104. All questions will be answered and will appear in this column as space permits.

BY ROBERT E. PEARSON, M.S.
FRED J. SALTER, PHARM. D.
ANN ARBOR

Q. Is there a drug to counteract the local irritation due to extravasation of levarterenol bitartrate (Levophed^{R})?

A. The local ischemia and sloughing due to prolonged extravasation of levarterenol may be counteracted by an infiltration of 5 to 10 mg. of phentolamine (Regitine®) in 10 to 15 ml. of sodium chloride injection.

Q. What is the fatal dose of hexachlorophene?

A. The fatal dose of hexachlorophene has been reported to be in the range of between two (2) and ten (10) grams. This amount of hexachlorophene can be found in between 67 ml. and 300 ml. of Phisohex®, Phisodan®, Soy-Dome Cleanser®, Turgex®, and Tridenhex Liquid.®

Q. Are there any specific ratios for mixing insulin preparations to suit the needs of particular patients?

A. The following table* briefly describes the optimum mixing ratios and the stability of the mixtures:

Insulins	Optimum Ratios	Stability
Regular-NPH	1:4-5	Immediately before use
Regular-Lente	1:1	Immediately before use
Regular-PZI	1:1	Mix anytime if using Lilly Insulins
Lente Preparations	Any Ratio	Mix anytime

* A complete description with documentation is available on request.

Q. What is the drug of choice for treatment of an LSD intoxication?

A. While chlorpromazine (Thorazine®) remains the best choice for a pure LSD ingestion, it is not always effective. "Bad trips" are often not solely due to LSD and may represent multiple drug ingestions. Diazepam (Valium®) may be of value, especially in the case of unknown or unconfirmed hallucinogen(s).

Abortion Law Reform Progress in Michigan

BY JACK M. STACK, M.D.
ALMA

When the Michigan Legislature convenes in January of 1970 one of the most difficult questions facing them will be that of the bills which have been introduced to change Michigan's abortion law.

It seems appropriate to review Michigan's present law and attempt to bring the interested physician up to date regarding the present proposals to change the law.

Michigan's present abortion law stems from the earliest days of statutory law in Michigan. The revised statutes of Michigan were passed in May 1848 and stated that the use of any drug or instrument with the intent to destroy the quick child, unless necessary to preserve the life of the mother, shall be deemed manslaughter, and the use of any drug or instrument with the intent to procure a miscarriage of the woman shall be punished by imprisonment for not more than one year or by a fine not to exceed $500.00 or by both.

EARLY ABORTION LAWS in Michigan and in the United States were influenced by the Ellenborough Act of 1803 in England. Prior to 1803 the common law in England did not consider an induced abortion before quickening to be a crime. In Blackstone's commentaries he states that "Life begins in the contemplation of the law when the infant is able to stir in the mother's womb." The Ellenborough Act distinguished between abortion before and after quickening by the fact that it was a felony in all cases but punishable by death only if done after quickening.

Early philosophers also distinguished between early and late gestation as St. Augustine held that the fetus was inanimate for a period of time (40 days in male embryos and 80 days in female), and that only abortion after "animation" was murder to be punished by death. St. Thomas Aquinas felt that life was demonstrated by two actions — knowledge and movement. He theorized that the soul was the first principle of life and that the soul entered the body of the fetus at the time of its first movement.

Michigan's law was first included in a criminal code when Public Act #328 was enacted into law in 1931. The law states that "any person who shall willfully administer to any pregnant woman any medicine, drug, substance or thing whatever, or shall employ any instrument or other means whatever, with intent thereby to procure the miscarriage of any such woman, unless the same shall have been necessary to PRESERVE the life of such woman, shall be guilty of a felony, and in case the death of such pregnant woman be thereby produced, the offense shall be deemed manslaughter."

A BRIEF SURVEY of the abortion laws of other countries is of interest.

Sweden's abortion law, passed in 1938, allows therapeutic abortions if the pregnancy severely jeopardizes the physical or mental health of the mother; if the pregnancy resulted from forcible rape or incest; or if there is a high risk of the baby being born with a grave deformity. Requests for abortions must be approved by Maternal Welfare Committees. All criminal abortions have not ceased in Sweden but because abortions are available through medical channels, the illegal abortionist has decreased his prices and improved the quality of his work. Maternal deaths from abortion have been eliminated in Sweden. It is known that about 25% of women whose requests are turned down ultimately obtain abortions. The remaining 75% obtain social aid, counseling, etc., and carry their babies to term. Attempts at self-induced abortion are now rare in Sweden.

Poland, Hungary, Czechoslovakia, Russia and Japan have allowed abortions upon request since World War II.

Prior to October 1967 the abortion law in England was similar to Michigan's law. In 1938 Aleck Bourne, a London surgeon, tested England's abortion law which, since 1861, had remained unchanged. It declared the use of any means with intent to effect a miscarriage, whether the woman was pregnant or not, to be a felony. Dr. Bourne performed an abortion on a 14-year-old girl who had been raped by two soldiers. He successfully defended his decision to abort the young woman

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The author is in private practice and is a member of the MSMS Committee on Legal Affairs, as well as an alternate delegate to the MSMS House of Delegates from the Gratiot-Isabella-Clare Counties Medical Society.

and was supported by prominent physicians throughout England. The judge in his summary to the jury stated that "Life depends on health," and that "It may be that if health is gravely impaired, death results. The law is not that the doctor has got to wait until this unfortunate woman is in peril of immediate death and then at the last moment, if successful, snatch her from the jaws of death."

IN OCTOBER 1967 the abortion law in England was changed by Parliament and reads as follows:

(1) A person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith —

  (a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated: or
  (b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(2) In determining whether the continuance of a pregnancy would involve such a risk of injury to health as is mentioned in paragraph (a) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(3) Any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State under the National Health Service Acts.

ENGLAND'S EXPERIENCE SINCE that time has been rather controversial. In 1966, the number of abortions in National Health Service hospitals was 6,380. During the first 13 months after the Abortion Act went into effect 41,496 abortions were recorded in England and Wales, 24,475 of which were done in the National Health Service hospitals. The remainder were done in licensed private clinics. Nearly three-fourths of the abortions are done on the grounds of "risk or injury to the physical or mental health of the woman."

Prior to 1967, 42 of our states including Michigan, considered abortion legal on only one ground, that was to preserve the life of the mother. Alabama, Oregon and Washington, D.C. allowed abortion to preserve life or health, New Mexico to prevent serious or permanent bodily injury, Massachusetts, New Jersey and Pennsylvania prohibit "unlawful" abortions with no further clarification of unlawful.

Since 1967 seven states have changed their laws. Colorado, Georgia, Maryland, North Carolina and New Mexico now allow abortions under the circumstances as outlined for Sweden's law.

California omitted the fetal deformity clause. Oregon added the reasonably foreseeable environmental clause as in the British law.

In April of 1968 the American College of Obstetricians and Gynecologists adopted a new policy on therapeutic abortion for medical indications which is as follows:

(1) When continuation of the pregnancy may threaten the life of the woman or seriously impair her health.

(2) When pregnancy has resulted from rape or incest: in this case the same medical criteria should be employed in the evaluation of the patient.

(3) When continuation of the pregnancy would result in the birth of a child with grave physical deformities or mental retardation.

In determining whether or not there is such risk to health, account may be taken of the patient's total environment, actual or reasonably foreseeable.

THE PRESENT CIRCUMSTANCES in Michigan are of interest.

Michigan had between 180,000 and 200,000 births per year between 1956 and 1965. We had about 60 maternal deaths each year. Analysis of the charts of these cases demonstrated that nearly 20 or 1/3 were the direct result of abortion, criminal or self-induced. No accurate public health records are kept concerning serious abortion morbidity, but we know that the toll is high. It is especially high among the poor, the non-white and the non-private patients. In a study from New York City 50% of the maternal deaths are due to abortion. 80% of these women are non-white, Negro or Puerto Rican. Of all hospital therapeutic abortions, 95% are on private patients with only 7% done on indigent patients. In addition many affluent women who are denied hospital abortions can and do travel to Puerto Rico, Mexico or Europe and obtain either a legal abortion or an illegal abortion but from a skilled abortionist. It is clear that many women in this country do not agree with our abortion laws and will go to drastic extremes to circumvent or violate our law often to their serious disadvantage. It is also clear that the main victims of the present abortion laws are the poor, the uninformed, the person without connections.

ONE MIGHT WONDER what the present practice is in Michigan.

In a report from the University of Michigan

Center for Population Planning, we find that 16 of 25 Michigan hospitals with obstetric residencies have replied to a questionnaire sent to them regarding abortion. Three of the 16 were Catholic hospitals where no therapeutic abortions were performed. In the remaining 13 hospitals, indications for the therapeutic abortion included medical, psychiatric, German measles in the first trimester, rape or incest, and a high chance of genetic defect in the infant. On a nation-wide basis 231 replies out of 500 inquiries resulted in the same pattern.

In August of 1968 the Michigan Council for the Study of Abortion surveyed all of the membership of the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons. Approximately 1/3 of the membership returned the questionnaire which was an unusually large response from physicians. They were asked to select one of the following options regarding the law:

(a) Eliminate the law as it refers to physicians.
(b) Revise the law, to allow abortion to be performed by a licensed physician at a licensed hospital for the preservation for the physical and mental health of the mother, or where the pregnancy resulted from forcible rape or incest, or when the fetus would be born with a grave physical or mental defect.
(c) Leave the law unchanged, with present degree of enforcement.
(d) Leave the law unchanged and more rigidly enforced.

Eighty-five per cent of all responses preferred (a) or (b), that the law be eliminated as it refers to physicians or be revised. Fifty-six per cent of all the Catholic physicians preferred (a) or (b); 95 per cent of the non-Catholic physicians preferred (a) or (b). The physicians were also asked to indicate the number of abortion requests they had received and the socio-economic status of the patient requesting the abortion, and from the data returned it is estimated that there are approximately 15,000 abortion requests of licensed physicians in Michigan each year. Eighty per cent of these are from white middle class women, 10% Negro women, 10% indigent.

In September of 1968 the Michigan State Medical Society House of Delegates passed a resolution which is probably one of the most liberal resolutions of any medical society in the country. The resolution reads:

Whereas, the current abortion laws of the State of Michigan are very restrictive so that only a very few women may receive legal abortions, and

Whereas, all of the current abortion law reform bills are limited in their scope so that very few women would have the right to obtain an abortion, and

Whereas, the right to bear a child should be primarily determined by the woman and her husband, therefore be it

RESOLVED: that the Michigan State Medical Society urge the Michigan Legislature to so alter the abortion laws that the criminal code will not apply to abortions performed by licensed medical and osteopathic physicians in accredited hospitals licensed by the State.

The House of Delegates also adopted a statement of guidelines to physicians regarding therapeutic abortion which is as follows:

> Therapeutic abortion is a medical procedure. Accordingly the Michigan State Medical Society recognized its responsibility to render available scientific medical information with respect to therapeutic abortion to legislators, authorized committees, the public, and finally and most importantly, the patients. Nowhere in the progression of therapeutic abortion legislation or practice should sight be lost of the fundamental principle that the primary decision belongs to the patient. This decision must be based on an informed understanding of the nature and the consequences of the therapeutic abortion and should be coupled with the informed consent of the husband, if any, and the parents and/or legal guardian if the patient is a minor. The Michigan State Medical Society respectfully recognizes that some physicians, because of moral or religious grounds, oppose liberalization of the abortion laws. Therefore, no physician or hospital should be compelled, directly or indirectly, to perform a therapeutic abortion.
>
> In view of the above, the Michigan State Medical Society believes that therapeutic abortion may be authorized subject to the following conditions:

1. A licensed medical or osteopathic physician perform the abortion in an accredited hospital licensed by the State.
2. Two other doctors of medicine or osteopathy concur in writing that one of the following conditions exist:
    (a) The abortion is deemed necessary to preserve the life of the pregnant female: or
    (b) The abortion is deemed necessary to preserve the physical or mental health of the pregnant female: or
    (c) That the infant may be born with incapacitating physical deformity or mental deficiency: or
    (d) The three doctors of medicine or osteopathy believe that the pregnancy resulted from forcible rape or incest.
3. Michigan State Medical Society does not condone the concept that an abortion be per-

formed on demand for any unwanted pregnancy or as a means of birth control. We do believe, however, that in determining whether or not there is a risk to the pregnant woman's life or health, account must be taken of the patient's total environment considering such factors as parity, contraceptive failure, socioeconomic stress, or marital or family stress when a woman does request a therapeutic abortion.

IT SHOULD BE EMPHASIZED that the guidelines to physicians are not proposed legislation. Recognizing the possibility that there might be some confusion as to the Michigan State Medical Society position, the 1969 House of Delegates passed free-tax free-standing Resolution regarding our legislative approach that Michigan State Medical Society urge the Michigan Legislature to so alter the abortion laws that the criminal code will not apply to abortions performed by licensed Medical and Osteopathic physicians in accredited hospitals licensed by the State.

THREE BILLS WHICH were introduced into the Senate and one in the House in 1969 are all still alive in 1970.

SB 288, introduced by Senator John McCauley (also sponsored by Senator Gilbert Bursley) states simply that any physician may perform an abortion upon his patient in any licensed hospital in this state and the question of whether or not to perform the abortion shall be a matter of concern solely between the physician and his patient and shall be subject to all the privileges of confidentiality as are other matters between a physician and his patient. SB 288 did not get out of committee in 1968.

Senator Bursley's bill SB 287 (co-sponsored by Senator McCauley) and HB 3364 are identical and would allow any physician to terminate the pregnancy of a woman after consultation with two other physicians in a licensed hospital upon the written request of the woman and upon the written certification by the physician and the consulting physicians, if one or more of the following conditions exist:

(a) There is significant risk that continuance of the pregancy would seriously impair the physical or mental health of the mother.
(b) The pregnancy resulted from rape or incest.
(c) There is significant risk that the child would be born with serious physical or mental defect.

If the application for termination of the pregnancy is based upon grounds of mental health of the mother one of the consulting physicians shall be a psychiatrist.

In the case of pregnancy caused by rape or incest the physician must notify the prosecuting attorney. If the prosecuting attorney notifies the physician within 7 days that there is no probable cause to believe that the alleged violation did occur the patient may petition the circuit court to determine whether the pregnancy did occur from rape or incest.

Authorization for the termination of pregnancy, with the certifications of the patient and physicians, shall become a part of the patient's record and shall be kept on file at the place where the procedure is performed.

The hospitals shall maintain records of these procedures and shall make these records available to the Department of Public Health maintaining the confidential nature of the records.

If the pregnancy is beyond the 19th week of gestation, the pregnancy may not be terminated unless there is significant risk that continuance of the pregnancy would seriously endanger the life of the mother.

FEW PEOPLE UNDERSTAND that there was a third bill, SB 374, which was introduced by Senator McCauley and was "the McCauley Bill" which did pass out of the Senate Committee on Health, Social Service and Retirement although it was moved back to committee without debate to keep it alive. SB 374 is essentially the position of Michigan State Medical Society. It is simply an amendment of the present abortion law to add the phrase, this law does not apply to abortions performed by licensed physicians in hospitals licensed by the State.

There is a rapidly growing support for the concept of SB 374. In addition to Michigan State Medical Society such organizations as the Democratic State Central Committee and the American Public Health Association have taken a position in favor of this concept.

There are outspoken critics of Abortion Reform such as Father Robert Drinan of Boston Law College who feel that repeal of the abortion law would be more acceptable than listing the circumstances under which the State would sanction the termination of a previable pregnancy.

The September 22, 1969 *American Medical News* reported a landmark decision in which the California Supreme Court ruled California's 1850 Abortion Law invalid and unconstitutional because it infringed upon a woman's right of privacy, and was unconstitutionally vague. It pointed out that the law put physicians in a position where they had an adverse interest in the patient. A "friend of the court" brief — submitted by medical school deans and faculty from across the country declared that "a statute designed in 1850 to protect women from serious risks to life and health has in modern times become a scourge."

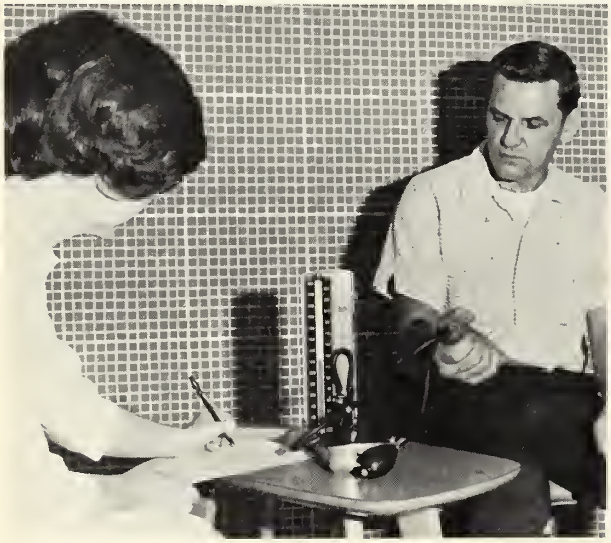
There are no criminal laws that state under what conditions physicians may remove the human heart and replace it with another heart, nor under what circumstances a physician may discontinue heroic efforts to preserve the life of a patient dying of terminal cancer. Neither should there be statutes in the criminal code which would regulate the delicate and personal question of whether or not a woman must carry a specific fetus to term in spite of her objection.

IN HIS INAUGURAL address at the 1969 House of Delegates the new President of the Michigan State Medical Society, Dr. Robert Mason, called upon the Michigan State Medical Society to work for meaningful reform of Michigan's Abortion Law. Our Legislators value highly personal communication from physicians in their representative and senatorial districts. They hear with great regularity from the opponents to change. It is time that they heard from the vast majority of the physicians in Michigan who do favor abortion reform.

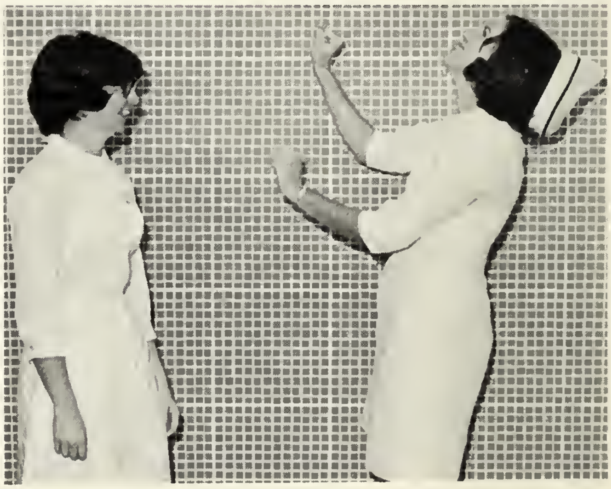
First Patient Enters Arthritis Control Center

THE FIRST PATIENT to enter the new arthritis control center at Henry Ford Hospital receives the careful attention of, from left, Carlina Jiminea, M.D., research fellow; Dwight Ensign, M.D., associate director; Gilbert Bluhm, M.D., and John W. Sigler, M.D., Henry Ford Hospital rheumatologists participating in the program. Ivan F. Duff, M.D., University of Michigan professor of internal medicine, is the director. The project, the first of its kind in the country to be federally-sponsored, is being conducted concurrently at Henry Ford Hospital and the Arthritis Section, University of Michigan Medical School, Ann Arbor.

THE PHILOSOPHY OF the program at the arthritis control center is that early diagnosis of arthritis can permit doctors to begin appropriate treatment to make a patient's life more productive. Group conferences with the patient and his family present, like the one above directed by John W. Sigler, M.D., second from right, are part of the treatment program.



ANOTHER PURPOSE OF the arthritis control center is to train physicians and other medical personnel in the management of patients with arthritis. Miss Clarice Brown, left, physical therapist, tests the patient's grip as he squeezes a modified pressure cuff, one of the first steps in entering a patient into the program.



THE PATIENT'S ABILITY to function is determined when he is first enrolled in the arthritis control center. Miss Kaye Owens, right, research nurse in the project, demonstrates the clenched fist pose which is photographed against a special grid designed for the test. The photographs are used for comparison during followup treatment. Looking on is Miss Clarice Brown, physical therapist.

Problems Resulting from Suppressible and Nonsuppressible Thyroid Function

BY DONALD A. MEIER, M.D.
JOEL I. HAMBURGER, M.D.
BOTH OF SOUTHFIELD

INTRODUCTION

The concept of a negative feedback autoregulation of function between the pituitary and its target organs, with the hypothalamus as a sensing and triggering body, is now accepted medical dogma. Thus, under normal circumstances, thyroid hormone in the blood stream in sufficient quantities, whether of endogenous or exogenous origin, will be detected by the hypothalamus, which in turn will curtail the transmission of thyrotropin releasing factor to the pituitary, so that secretion of thyroid stimulating hormone (TSH) and thyroid gland function will be suppressed. Similarly, it is axiomatic that in hyperthyroid states thyroid hormone secretion persists in spite of abnormally high circulating levels of this hormone. In fact, this is the basis for the very valuable Werner T_3 (Liothyronine) suppression test.[1] More recently it has been appreciated that thyroid function (in terms of radioactive iodine uptake) may be nonsuppressible, or only partially suppressible, in certain patients who are not hyperthyroid. Included are those with early stages in the development of Graves' disease,[2] with nontoxic autonomous thyroid nodules,[3] or multinodular goiter.[4]

That some patients may manifest either inappropriate or changing suppressibility of thyroid function in response to the administration of thyroid hormone, whether for diagnostic or therapeutic purposes, may not generally be appreciated. However, unless the circumstances under which unexpected responses may occur are anticipated, or at least recognized, confusion and mismanagement may result.

It is the purpose of this paper to exemplify by means of brief case reports the following potential problem situations with respect to unexpected suppressible or nonsuppressible thyroid function:

1. Hyperthyroidism in a patient with suppressible radioactive iodine uptake;
2. The emergence of nonsuppressible function in a patient under treatment for goiter with thyroid hormone, when function had previously been suppressible;
3. The persistence of nonsuppressible function in a patient following treatment of hyperthyroidism;
4. Subnormal, but nonsuppressible function in a patient following 131-I therapy of hyperthyroidism.

The significance of these observations will be discussed in terms of current trends in the diagnosis and management of hyperthyroidism.

MATERIALS AND METHODS

Between 1961 and 1969 the authors have provided an outpatient diagnostic and therapeutic laboratory for referral of thyroid problems by physicians of metropolitan Detroit. During this period of time, in excess of 7,000 patients have been evaluated. Four hundred and fifty patients have received radioactive iodine therapy for hyperthyroidism. A roughly equivalent number have been seen following thyroidectomy for hyperthyroidism. From this group of patients four have been selected for presentation and discussion because they exemplify the problems which may result from unexpected suppressible and nonsuppressible thyroid function, and the fluctuations in suppressibility of thyroid function which may occur both before and after treatment of hyperthyroidism.

CASE REPORTS

Case 1. A 30-year-old woman complained of nervousness, 15 pound weight loss in spite of increased food intake, palpitation, and tremulousness. On examination, there was lid lag, a fine tremor, pulse rate of 120 per minute, and a small diffuse goiter. The 24-hour radioactive iodine (RAI) uptake was 32 percent, and the thyroid gland appeared to be about twice normal size on scan. A protein-bound iodine (PBI) was 9.3 pg percent (normal range 4.0 to 8.0). Following the

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administration of T_3 (CYTOMEL^R), 100 µg daily for seven days, a repeat 24-hour RAI uptake was nine percent. Although the clinical diagnosis of hyperthyroidism seemed very clear, the results of the T_3 suppression test were disconcerting. Accordingly, a therapeutic trial with lugol's solution, 3 drops daily, was elected. After two weeks of treatment there was marked improvement in her symptoms, she had regained 7 pounds, and her pulse rate had slowed to 80 per minute. Iodides were discontinued, and a 24-hour RAI uptake of 30 percent was achieved in two weeks. She was then given a 3 mc therapy dose of 131-I. Three months later, she was still clearly hyperthyroid. The 24-hour RAI uptake was 73 percent, and the thyroid gland appeared unchanged on scanning. The PBI was 10.2 µg percent. An additional 2 mc of 131-I was given. This led to a restoration of the euthyroid state within three months.

Comment: This is the only patient we have encountered with a suppressible RAI uptake while hyperthyroid. We have been accustomed to place such great reliance upon the results of the T_3 suppression testing that in spite of clinical evidence and an elevated PBI to the contrary, we were deterred from definitive therapy until the response to stable iodine eliminated all possible doubt as to the diagnosis of hyperthyroidism.

Case 2. A 46-year-old euthyroid woman presented for evaluation of a large goiter of many years duration. The 24-hour RAI uptake was 12 percent, and the PBI was 5.2 µg percent. Between December of 1961, and July of 1963, she was treated with levothyroxine in doses between 0.2 and 0.3 mg daily. Her husband died in May of 1963, and following this she rather rapidly developed manifestations of hyperthyroidism. On 7-3-63, the 24-hour RAI uptake was 46 percent, and she had still been taking levothyroxine 0.2 mg daily up to the day of the test. She was treated with 30 mc of 131-I. Four months later (11-4-63), she was mildly hypothyroid. The 24-hour RAI uptake was 3 percent. Treatment was reinstituted with levothyroxine, 0.2 mg daily. On 5-6-64, she appeared mildly hyperthyroid. The 24-hour RAI uptake (she was still taking levothyroxine 0.2 mg daily) was 22 percent. Thyroxine was stopped. She has remained euthyroid on annual follow up examination for five years.

Comment: This patient demonstrates the rather abrupt evolution of nonsuppressible function in a patient who had previously tolerated suppression therapy with thyroid hormone for approximately 18 months. In addition, although she became transiently hypothyroid after 131-I therapy, within six months function had not only recovered, but was again nonsuppressible. Manifestations of hyperthyroidism recurred as a consequence of the summation effect of the endogenous secretion of thyroid hormone, plus the exogenous thyroxine, prescribed for her earlier hypothyroidism. Discontinuation of the thyroxine medication led to restoration of the euthyroid state, since the limited functional capacity of the gland following 131-I therapy was inadequate to support hyperthyroidism, even though that residual function was nonsuppressible.

Case 3. A 44-year-old woman gave a history of three attempts at surgical management of Graves' disease between 1959 and 1965. Between June of 1968 and 1-23-69, she had taken levothyroxine 0.2 mg daily. On 1-23-69 she appeared moderately hyperthyroid. The 24-hour RAI uptake was 24 percent (she was still taking levothyroxine 0.2 mg daily), and the serum thyroxine level (T_4) was 8.0 µg percent (normal range 2.9 to 6.4 µg percent). The thyroid scan revealed four areas of residual functioning thyroid tissue, including one compatible with the pyramidal lobe.

Comment: This case demonstrates persistent nonsuppressible thyroid function after surgical treatment of hyperthyroidism.

Case 4. A 28-year-old hyperthyroid woman was referred for treatment. The 24-hour RAI uptake was 67 percent, the scan revealed a goiter two and one-half times normal size. She was given 4 mc of 131-I on 9-28-66, but failed to respond. A second dose of 10 mc was given on 12-17-66. On 4-3-67, she was distinctly hypothyroid; the 24-hour RAI uptake was 6 percent, and the T_4 was 1.4 µg percent. Treatment was instituted with levothyroxine 0.2 mg daily. On 5-25-67 mild evidence of hyperthyroidism (weight loss, tremor and tachycardia) was detected. The RAI uptake on levothyroxine was 12 percent, the T_4 8.7 µg percent. Thyroxine was discontinued. On 7-31-67 the patient again was hypothyroid. The RAI uptake was 24 percent, but the T_4 was only 1.7 µg percent. Treatment with levothyroxine 0.1 mg daily was started, and has been maintained since then. The 24-hour RAI uptake on 4-23-68 was 28 percent, and the T_4 was 4.5 µg percent. The patient felt fine.

Comment: This patient became hypothyroid after 131-I therapy, but function partially recovered. Thyroid hormone production was inadequate to maintain the euthyroid state, but the remaining function was nonsuppressible. Therefore, partial substitution therapy was necessary with the final circulating thyroid hormone level being the resultant of endogenous and exogenous components.

DISCUSSION

The significance of normal and abnormal responses of the RAI uptake to suppressive doses of thyroid hormone has been thoroughly discussed in the literature. It is accepted that in hyperthyroidism the RAI uptake is nonsuppressible, and that patients with suppressible uptake are not hyperthyroid. Case 1 of this report is an exception to this rule. Although most rules in medicine have exceptions, it is difficult to understand how a patient with suppressible thyroid function can become hyperthyroid. It is basic to the concept of hyperthyroidism that the thyroid gland continues to function, in terms of synthesis and secretion of its hormone, in spite of elevated circulating levels of this hormone. If the thyroid function were to become suppressed, then one would expect hyperthyroidism to cease. If it is agreed that LATS is a stimulating factor causing hyperfunction of the thyroid gland in Graves' disease, and that LATS is a gamma globulin arising from lymphocytic tissue, it is even more difficult to conceive how an increased level of thyroid hormone could affect LATS activity. One might speculate that there could be either some degree of feedback regulation of LATS production and/or release, or an impairment (transient?) in LATS production by higher levels of thyroid hormone in the early stages in the development of Graves' disease. However, there is no data to support either of these proposals. In spite of the lack of explanation for the observation of suppressible function in the hyperthyroid patient, it remains important to recognize that one cannot place absolute reliability upon the concept of the nonhyperthyroid significance of a suppressible RAI uptake.

Case 2 shows that an uptake which is suppressible need not remain so. It is obvious that hyperthyroid patients, prior to becoming hyperthyroid were euthyroid, and probably had suppressible function. Hence, the possibility of a progression from suppressible to nonsuppressible function should not be a concept foreign to the thinking of physicians who administer thyroid hormone to patients as treatment for goiter. Nevertheless, once or twice each year, we encounter a hyperthyroid patient who has been taking thyroid hormone, and for whom the evolution of nonsuppressible function with subsequent hyperthyroidism was unrecognized by the attending physician. The development of hyperthyroidism in patients taking thyroid hormone was also recognized by Dymling and Becker.[5] They reported 23 patients who developed hyperthyroidism under these circumstances. They reviewed the literature, and found approximately 100 additional patients who exemplified this transition. Of their 23 patients, one could not be certain how many had suppressible function prior to treatment with thyroid hormone. Five of the 23 received thyroid hormone for less than two months, and presumably might have had nonsuppressible function from the very beginning. However, 12 patients received thyroid hormone for over a year before the diagnosis of hyperthyroidism was made, and it seems likely that these patients had suppressible function initially. More recently Santis and Sisson have reported that patients receiving thyroid hormone for nontoxic nodular goiter and ophthalmopathy may become overtly hyperthyroid because of underlying nonsuppressible function.[6] Therefore, it is important that every physician who administers thyroid hormone be alert to the possibility of the development of nonsuppressible function. Manifestations of hyperthyroidism in such patients call for an immediate RAI uptake, *without* discontinuing the thyroid hormone. This is the most definitive manner in which to demonstrate that nonsuppressible function has developed.

Case 2 also demonstrates recovery from transient hypothyroidism after 131-I therapy, with restoration of nonsuppressible function. Of greatest current interest with respect to 131-I therapy of hyperthyroidism is the problem of post-treatment hypothyroidism, and how to avoid it. The routine use of thyroid hormone has been suggested as a measure to this end.[7] If all hyperthyroid patients were rendered permanently hypothyroid, or at least had suppressibility of function restored, this recommendation might be safe. However, nonsuppressible function may persist after correction of the hyperthyroidism. Case 3 shows that this may occur whether the patient is treated with radioiodine or surgery. Furthermore, nonsuppressible function may even be present when the remaining function is inadequate to maintain the euthyroid state. This problem is demonstrated by Case 4. The presence of persistent nonsuppressible function in patients with Graves' disease rendered euthyroid with therapy has also been noted by Hennemann and Bussemaker.[8] They found nonsuppressible residual function in 6 out of 20 patients made euthyroid with surgery, 1 of 3 patients treated with 131-I, and 1 out of 10 patients restored to a euthyroid state with antithyroid drugs.

Finally, the functional capacity of the post-therapy thyroid remnant in terms of both hormonal output and suppressibility is not a static phenomenon, but may increase or decrease in the first few months after therapy, and more likely will decrease gradually in the years thereafter. Hence, regular observations are necessary indefinitely for hyperthyroid patients. For the first year, the patient should be seen at three month intervals. Annual examinations after the first year should be adequate.

SUMMARY

Too rigid acceptance of nonhyperthyroid significance of a suppressible RAI uptake, or failure to anticipate the changes in suppressibility of thyroid function which may precede or follow treatment of hyperthyroidism may lead to incorrect diagnosis and/or management. All patients treated with thyroid hormone for goiter suppression should be observed at regular intervals for the possibility of the development of nonsuppressible function. Following treatment of hyperthyroidism with 131-I or surgery, residual function may re-

main nonsuppressible, even when inadequate to maintain the euthyroid state. Furthermore, this residual post-therapy function may increase or decrease in the early post-therapy period, but over the years tends gradually to decrease. Because of these changes, it is essential to re-evaluate thyroid function in all treated hyperthyroid patients at regular intervals, indefinitely.

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Pulmonary Hypertension— A Complication Of Aortic Valve Disease

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Pulmonary hypertension as a complication of aortic valve disease is not a well-recognized entity. Our recent experience at the Ann Arbor Veterans Administration Hospital prompted this review.

The development of an effective prosthesis for replacement of the aortic valve has offered an operation to patients with irreversibly damaged aortic valves. Because the natural history of patients with symptomatic aortic valve disease is ominous, the replacement of the diseased aortic valve should be carried out once the patient develops significant symptoms. Pulmonary hypertension as a late sequela of long standing mitral valve disease is a well-recognized entity. However, it is not commonly appreciated that in severe aortic valve disease, pulmonary hypertension may also develop. This paper reviews our experience at the Ann Arbor Veterans Hospital during the last four years with patients having symptomatic aortic valve disease associated with pulmonary hypertension.

Thirteen patients presented with symptomatic aortic valve disease. Eleven had predominant aortic stenosis while two had predominant aortic insufficiency. Nine patients had elevated pulmonary artery pressures.

Five had mild pulmonary hypertension with pulmonary artery pressures greater than thirty mm. Hg. systolic but less than fifty mm. Hg. systolic. Four patients had severe pulmonary hypertension with pulmonary artery pressures greater than seventy mm. Hg. systolic. All of the patients had symptoms of angina, syncope, or congestive heart failure alone or in combination. Left ventricular hypertrophy or strain was demonstrated by the electrocardiogram in all patients. Concentric hypertrophy or dilation of the left ventricle was apparent in all thirteen patients in their chest roentgenograms. All the patients were functional class III or IV according to the New York Heart Association criteria.

OPERATIVE TECHNIQUE

The heart was exposed through a median sternotomy incision and cardiopulmonary bypass established. Mild total hypothermia to 30° C. was used. To insure myocardial protection during aortic cross clamping, both coronary arteries were continuously perfused. After excision of the diseased aortic valve, a Starr-Edwards prosthesis was sutured in place with multiple interrupted sutures.

Postoperatively, an endotracheal tube was left in place overnight to provide assisted ventilation. The morning following the operation, if assisted ventilation was still required, a tracheostomy was performed. Tracheostomy was performed at the conclusion of the operation for those patients with severe pulmonary hypertension, and ventilation was assisted for about seven days. Ventricular arrhythmias were controlled by either lidocaine or electrical pacing through temporary myocardial electrodes. Low cardiac output in the immediate postoperative period was treated with Isuprel infusion, which in addition to its ionotropic effect on the myocardium, also enhances peripheral circulation by its vasodilator effect. Anticoagulation with Warfarin was begun during the first postoperative week and was continued indefinitely unless individually contra-indicated. Antibiotics were

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TABLE 1

								OUTCOME	
	Patient	A. S.	A. I.	P. A.	Functional Class Preop.	Preop. Sympt.	Date of Operation	Functional Class	Heart Size on X-Ray
1.	R. S.	3+	1+	70/32	III	Angina	11/66	Died 2 months post op.	———
2.	G. K.	0	3+	35/14	III	Syncope	3/68	II	Same
3.	L. H.	3+	0	30/15	III	CHF	4/65	I	Smaller
4.	L. B.	3+	2+	30/10	IV	Angina	12/64	I	Smaller
5.	J. J.	3+	0	25/8	III	CHF	8/65	Operative death	———
6.	G. U.	0	3+	70/30	IV	Syncope	3/65	I	Smaller
7.	C. S.	2+	3+	75/35	IV	CHF Angina	6/68	II	Same
8.	A. P.	0	3+	27/10	IV	Angina CHF	4/68	II	Same
9.	W. S.	3+	1+	30/13	III	CHF	11/67	Operative death	———
10.	L. K.	3+	2+	26/10	III	CHF Angina	4/67	Died 8 months post op.	Same
11.	R. C.	3+	0	75/30	III	CHF	10/65	Died 3 years post op. II	Same
12.	C. S.	3+	1+	27/8	III	CHF Angina	6/68	II	Same
13.	O. C.	3+	1+	40/20	IV	CHF Angina	1/67	II	Same

begun 24 hours before the operation and continued for three months postoperatively.

RESULTS

Although nine patients had pulmonary hypertension, there were only two operative deaths. Patient No. 5 (table) had severe coronary artery disease, and the patient died because it was impossible to accomplish adequate coronary artery perfusion. Patient No. 9 developed a bleeding diathesis postoperatively. Despite two re-explorations, he expired from uncontrollable hemorrhage.

Late deaths occured in three of the operative survivors. Patient No. 1 died of a myocardial infarction two months postoperatively. At autopsy, fibrosis of the ostia of the coronary arteries was found. Patient No. 10 died suddenly eight months postoperatively without a known cause. Patient No. 11 died of Hodgkins disease three years after a successful aortic valve replacement. All of the patients who recovered from the operation were improved, and three of the long-term survivors are asymptomatic. The heart remained increased in size in four of seven patients with pulmonary hypertension.

Two of the patients developed systemic arterial embolization despite the use of long-term oral anticoagulants. Neither embolus was fatal, and there were no sequelae.

DISCUSSION

In patients with aortic stenosis, there is a relatively long latent period, marked by increasing left ventricular obstruction, prior to the onset of symptoms. However, once the patients develop either angina, syncope, or congestive heart failure, their course is one of progressive deterioration, with an average life expectancy of four years.[1]

In postmortem studies, the average age of death in patients with aortic stenosis is 63. The average duration of symptoms prior to death is three years for angina and syncope and two years for congestive heart failure. In recent prospective studies, 15 patients who did not undergo operation were followed for periods up to 12 years after initial hemodynamic studies. Ten of the 15 patients were dead at the end of the follow-up period.[2]

SUDDEN DEATH occurs in about 15 percent of patients who die with valvular aortic stenosis. However, 80 percent of these patients have symptoms of angina, congestive heart failure, or syncope before death; and, therefore, only 3 to 5 percent of sudden deaths occur in asymptomatic patients.

In patients with aortic insufficiency, there is a relatively long latent period prior to the onset of symptoms.[3] Once the patient develops either angina or congestive heart failure, his course is one of progressive deterioration with an average life expectancy of ten years. In postmortem studies, the average age of death in patients with aortic insufficiency is 40. The course after symptoms appear is longer than that for aortic stenosis, but the onset of symptoms occurs at a much earlier age. There is also a 5 percent incidence of sudden death in those with symptoms.

Operation is recommended for any patient with aortic valve disease who has symptoms of angina, syncope, or congestive heart failure. If there is a 50 mm. gradient across the aortic valve, operation is recommended regardless of symptoms. For asymptomatic patients with a gradient of less than 50 mm. Hg., operation is not recommended since the operative mortality is greater than the risk of sudden death.

THE PATHOGENESIS of pulmonary hypertension in aortic valve disease is related to the development of a high left ventricular end diastolic pressure (LVEDP).[4] The LVEDP is a rough measure of end-diastolic volume and is elevated in left ventricular failure. In the absence of mitral valve stenosis or other obstruction to left atrial outflow during diastole, there is free flow of blood from the pulmonary artery to the left ventricle. In early diastole, there is a gradient across the pulmonary capillary bed; but in mid and late diastole, blood flows slow, and the pressures equilibrate from the pulmonary artery to the left ventricle. For this reason, the diastolic pressure in the pulmonary artery has been assumed to reflect almost exactly the LVEDP, and this has consistently been the finding in our laboratory.

In severe aortic stenosis or aortic regurgitation, the LVEDP is often markedly elevated, sometimes as high as 20-30 mm. Hg. In such cases the PA systolic pressure maintains the normal ratio of two to three times PA diastolic pressures up to 9 mm. Hg. The pulmonary hypertension is a reflection of left ventricular hemodynamics and does not signify increased pulmonary vascular resistance.

The incidence of pulmonary hypertension in this series is considerably higher than that reported by Kahn and associates[5] at the University of Michigan. In this series only 15 percent of the patients undergoing aortic valve replacement had pulmonary hypertension, and no patients had severe pulmonary hypertension.

IN OUR series nine of the thirteen patients had pulmonary hypertension, and four of these had severe pulmonary hypertension. This correlates with high LVEDP and large end-diastolic volume and reflects the advanced disease in these patients. The operative mortality of patients with pulmonary hypertension was not greater than the operative mortality of patients who did not have pulmonary hypertension, but the long-term results were not as good. Four of the seven patients with elevated pulmonary pressures continued to have cardiac enlargements postoperatively.

This is to be contrasted with the results of Kahn and his associates who found in a larger series of patients operated upon at the University of Michigan Medical Center that 25 percent of patients had persistent cardiomegaly without pulmonary hypertension.[5] In addition these authors reported that 60 percent of patients undergoing aortic valve replacement without pulmonary hypertension were asymptomatic six months after operation, while only three of our patients who had pulmonary hypertension are in this category in the same period of time.

The results of aortic valve replacement in this small series of patients suggest that results will be less good following operation for patients with pulmonary hypertension. Better results were obtained in patients who were operated upon before pulmonary hypertension developed. However, patients who have developed pulmonary hypertension should not be denied operation, because these patients can still be improved by aortic valve replacement.

SUMMARY

Our experience with a small group of patients having aortic valve disease and associated pulmonary hypertension is presented. The relation of the pulmonary hypertension to the aortic valvular disease is suggested.

Patients whose aortic valve disease is complicated by pulmonary hypertension have poorer long-term results following aortic valve replacement than those without pulmonary hypertension. Operation should not be denied patients with pulmonary hypertension because these patients can still be improved by aortic valve replacement.

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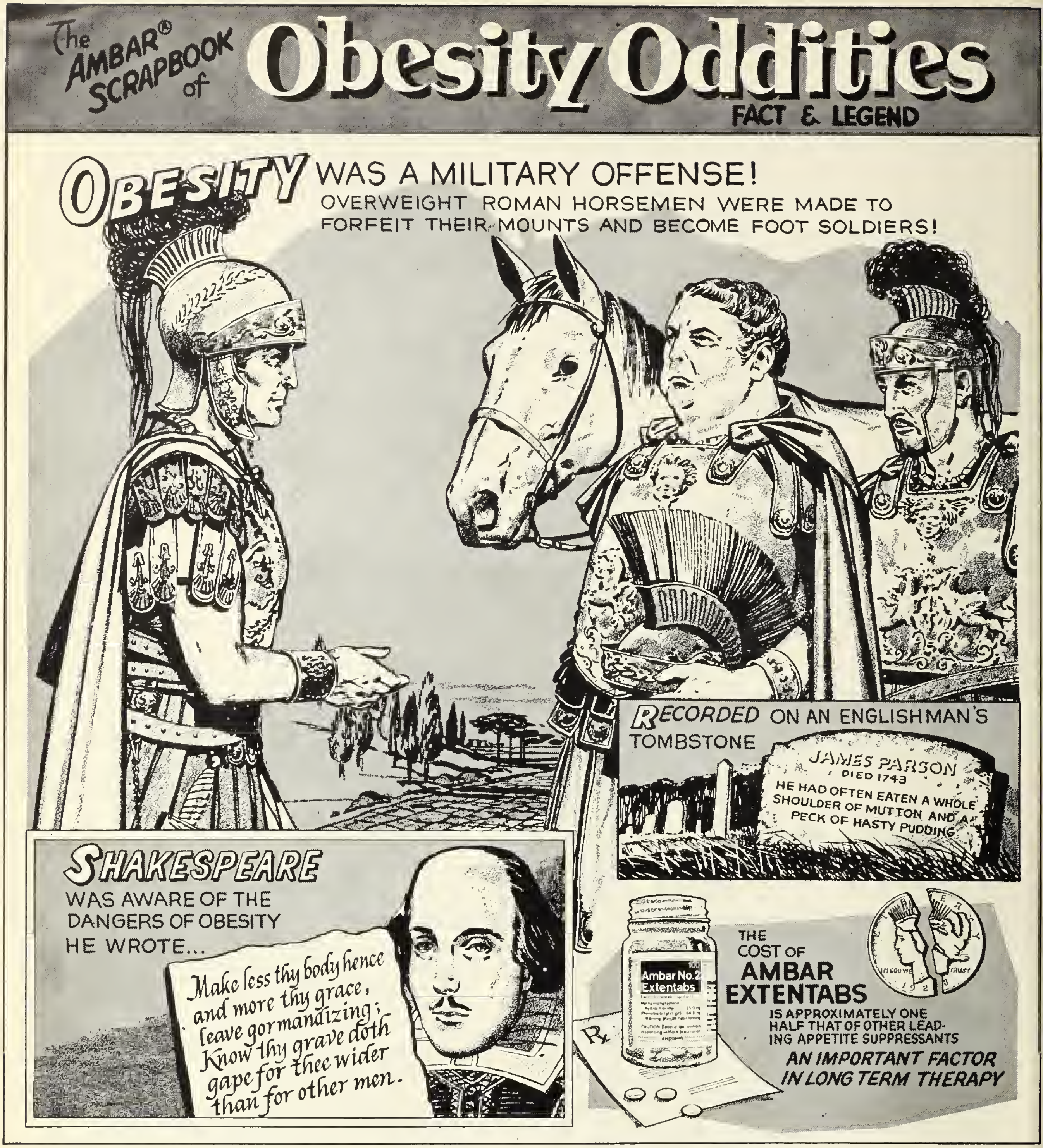
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A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

Ovulen-21 Compack
Directions

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began
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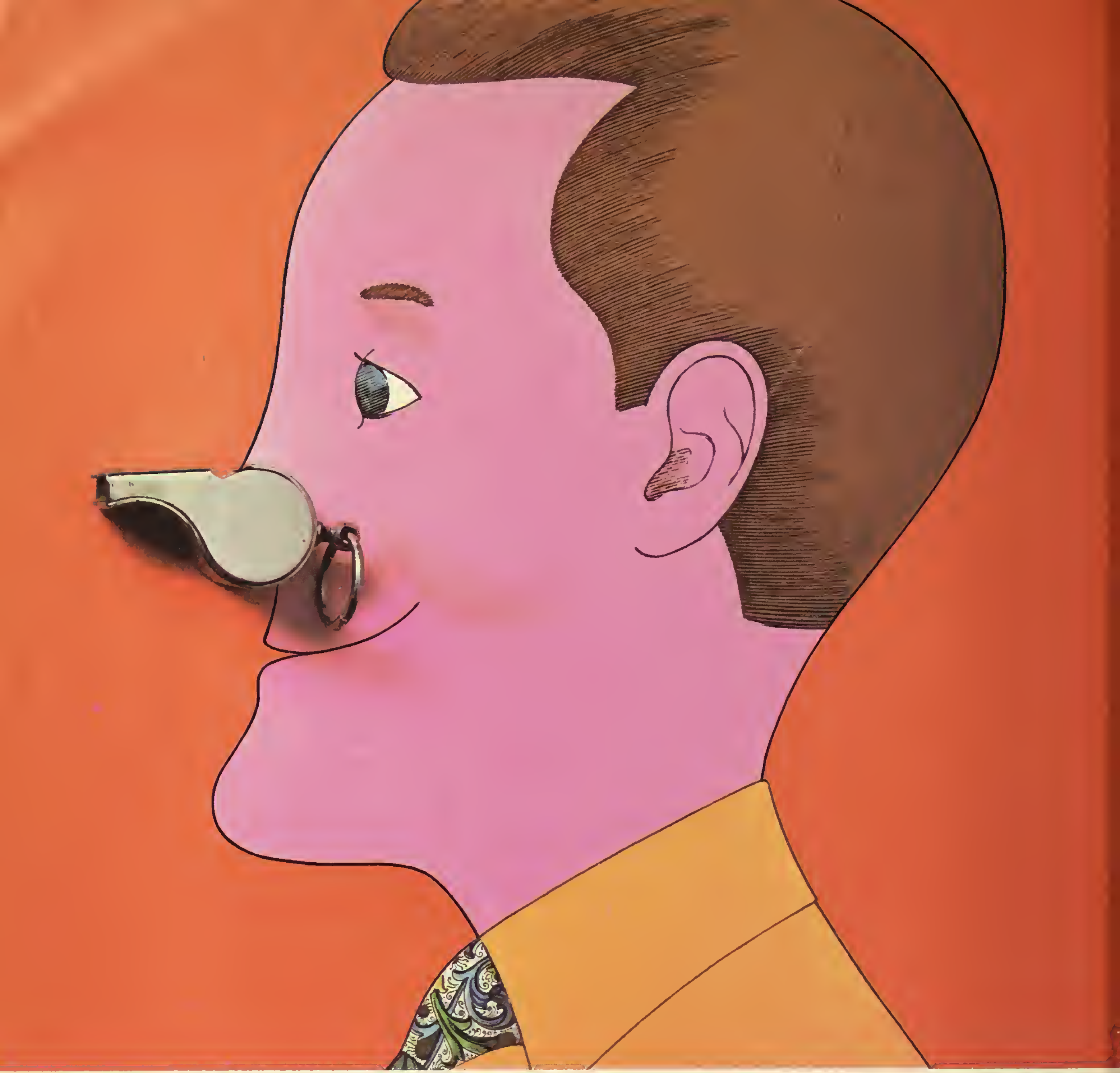

Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

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Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

Dosage: 1 Extentab morning and evening.

Supplied: Bottles of 100 and 500.

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Michigan Mediscene

Jan. 16-17 — 18th ANNUAL WSU SYMPOSIUM ON BLOOD, McGregor Memorial Conference Center, Detroit

Jan. 24 — MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY 1970 MID-WINTER SEMINAR, Holiday Inn, Crosstown Parkway, Kalamazoo

Jan. 26 — MSMS WOMAN'S AUXILIARY, MSMS Headquarters, East Lansing, All Day

Jan. 28 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Mar. 11 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Mar. 25-26 — 9th ANNUAL CONFERENCE ON MATERNAL AND PERINATAL WELFARE, sponsored by MSMS and the Clara Elizabeth Fund, Pick-Durant Hotel, Flint

Apr. 22 — MSMS COUNCIL, Towsley Center, Ann Arbor, 9:30 a.m.

Apr. 23-26 — MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY ANNUAL MEETING, Pontchartrain Hotel, Detroit

Apr. 30 — FIFTH ANNUAL 1970 MSMS CONFERENCE ON MEDICAL ASPECTS OF HIGH SCHOOL SPORTS, Towsley Center, U-M, Ann Arbor

May 6-8 — MICHIGAN PUBLIC HEALTH ASSOCIATION ANNUAL MEETING, Statler-Hilton Hotel, Detroit

May 21-22 — MSMS ANNUAL MATERNAL HEALTH CONFERENCE, Kellogg Biological Station, Gull Lake

May 27 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

June 17 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 12:00 noon

June 21-25 — American Medical Association Annual Convention, Chicago

July 23-25 — MSMS COUNCIL, Grand Hotel, Mackinac Island

Sept. 23 — MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit, 8:00 a.m.

Sept. 25-Oct. 2 — American Academy of General Practice Scientific Assembly, San Francisco

Nov. 4 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 12:00 noon

Nov. 29-Dec. 2 — American Medical Association Clinical Convention, Boston

MSMS HONORS EMPLOYEES

COUNCIL CHAIRMAN Ross V. Taylor, M.D., left, presented an MSMS service award and emblem at the 1969 Annual Session to Associate Executive Director Warren F. Tryloff, for his 15 years with MSMS.

HONORED FOR 10 years of service with MSMS was Herbert A. Auer, right, MSMS public relations officer and executive editor of **Michigan Medicine,** who also received his award from Council Chairman Ross V. Taylor, M.D., Jackson.

ANNUAL SESSION ceremonies also included the presentation of a service award and emblem to Maynard J. Hoover, MSMS production manager, who has served the Society for five years.

Mead Johnson—pharmaceuticals created for your specialized clinical needs
new solution...
to help your patients open mucus-clogged airways

new 10% solution...

particularly convenient for home use

MUCOMYST®-10

(ACETYLCYSTEINE)

liquefies thick, viscid mucus in chronic bronchitis and emphysema

Mucomyst, as 20% acetylcysteine, has been used with safety and effectiveness in hospitals for over five years.

Now a new 10% solution, Mucomyst-10, offers you the choice of prescribing a lesser concentration whenever you feel this is desirable. It provides added convenience and simplicity, particularly for your patients using nebulizing units at home.

By including Mucomyst-10 in the home management regimen, you can provide full mucolytic benefits for many of your patients with chronic bronchitis and emphysema complicated by tenacious secretions.

Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings: After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched carefully. If bronchospasm progresses, this medication should be immediately discontinued.** **Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied: Mucomyst-10 (acetylcysteine)**, a sterile 10% solution, in vials of 10 ml. and 30 ml.; **Mucomyst (acetylcysteine)**, a sterile 20% solution, in vials of 10 ml. and 30 ml.

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council minutes

Meeting of Nov. 4 and 5, 1969

Council Moves Along Umbrella Insurance Plan

MSMS BUDGET — The Council heard a report by Mr. Robert White, C.P.A., a general partner in the Alexander Grant Company, Detroit, on the MSMS system for financial reporting and budgeting devised and adopted in 1964. Mr. White described the development of the budget, pointed out its flexibility and outlined the systems of controls that are inherent in the plan.

CONTINGENCY FEES — The Council moved that the MSMS delegates to the AMA be urged to request the AMA legal counsel to help draft a resolution to study the proposition of removing contingency fees from malpractice cases.

UMBRELLA INSURANCE — The Council accepted the proposal of the Employers-Commercial Union Group Insurance Company for an umbrella excess policy of liability insurance. The employers proposal, recommended by Ben Stratton, MSMS insurance counsel, was approved after review of proposals by two other companies active in this area. Information will be sent soon to MSMS members.

MIDSUMMER SESSION — The Council decided to hold its 1970 Midsummer Session on July 22-26 at The Grand Hotel, Mackinac Island.

MEDICAID PAYMENTS — The Council approved, in principle and subject to the chairman's modification, a reply to State Senate Finance Committee Chairman Charles O. Zollar detailing what The Council thought should or could be done to provide some control of Medicaid costs and quality. The letter was requested by Senator Zollar's committee following a meeting Oct. 9 with MSMS representatives to discuss Medicaid payments to physicians. The Council's reply through chairman Doctor Taylor appears on the first page of the Breaking News section (blue pages) of the December *Michigan Medicine.*

ANNUAL SESSION — The Council heard a report that attendance at the 1969 Annual Session improved over the previous year, a significant gain since it is contrary to the downward trend in attendance at most state medical society annual meetings. It was reported that attendance at the all-day postgraduate meetings was especially good and that the over-all good attendance likely was due to the format of the scientific program and its quality. Without exception, exhibitors were reported to be pleased with the exhibit arrangements and physician interest.

FUTURE MEETINGS — Suggested dates for MSMS Annual Sessions on Oct. 6-10, 1974 and Oct. 5-9, 1975, both at the Sheraton-Cadillac Hotel in Detroit, were approved.

RVS REVISION — The Council referred to its County Societies Committee the matters of establishing a new unit value for the Relative Value Study (which was established five years ago) and publishing the 1969-70 RVS without relative values.

CRASH INJURIES — The Council heard a report that routine letters were sent in October to members of 16 component medical societies in the new study areas (beginning Nov. 1, 1969) for the Michigan-Cornell Automotive Crash Injury Research Project. The component societies included in the new study areas are Allegan, Barry, Berrien, Branch, Cass, Kalamazoo, Kent, Lapeer, Macomb, Monroe, Oakland, St. Clair, St. Joseph, Van Buren, Washtenaw and Wayne.

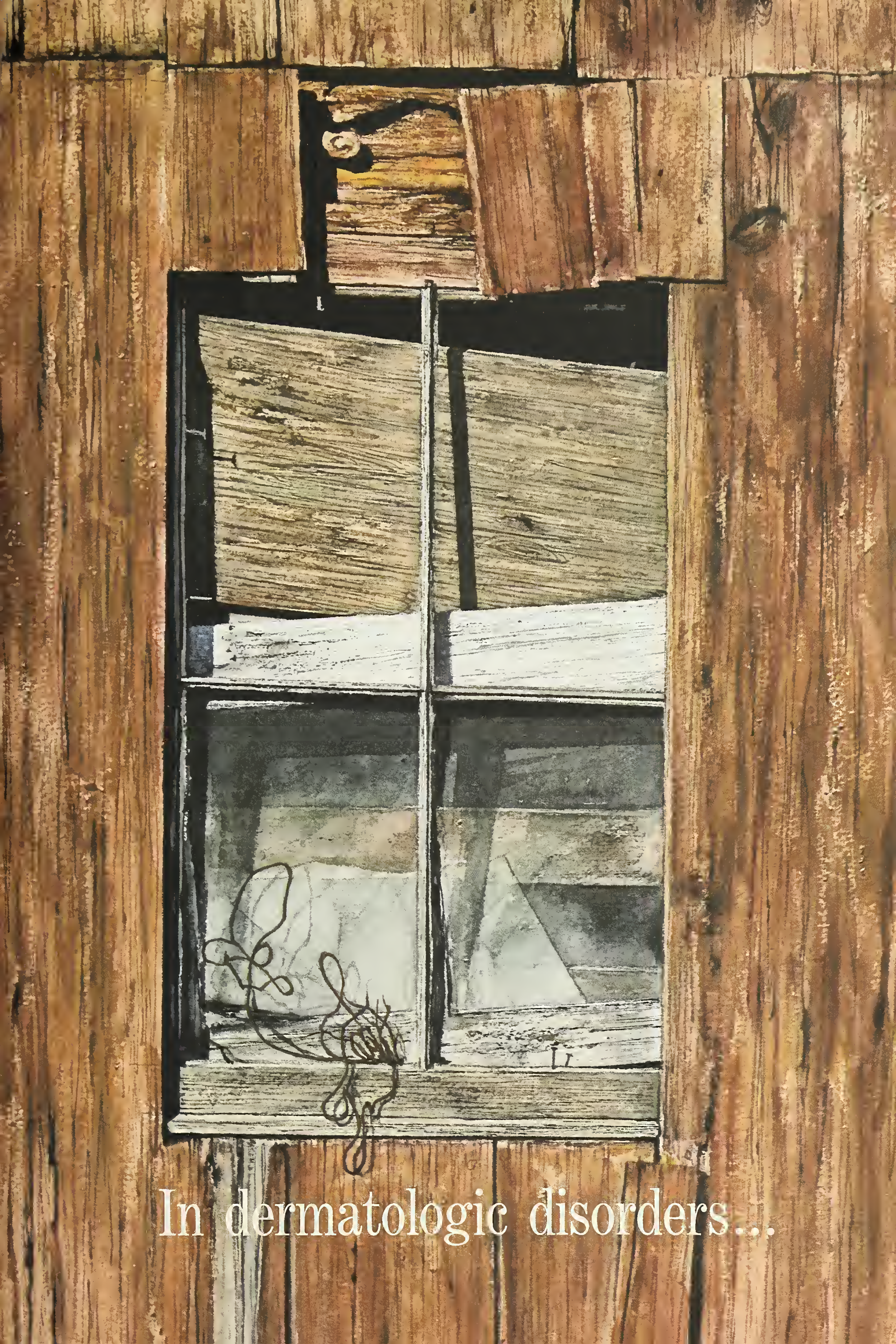
"FEE FREEZE" — The Council approved sending a letter to each Michigan congressman discussing the legality of the Title 18 and 19 "fee freeze."

COUNCIL COMMENDATION — The Council approved presentation of a special framed citation to E. F. Sladek, M.D., Traverse City, "In deep appreciation and grateful recognition of distinguished service rendered to Medicine as president (1948) and chairman of The Council (1944-47) and for outstanding accomplishment in behalf of his profession and the public."

OSTEOPATHIC REPRESENTATION — The Council approved sending a letter to the Michigan Association of Osteopathic Physicians and Surgeons requesting representation from their Committee on Maternal Health to the MSMS Committee on Maternal and Perinatal Health.

NEW CONFERENCE — The Council authorized the MSMS Committee on Maternal and Perinatal Health to explore further the need for a possible conference on perinatal mortality in urban areas and to develop for The Council preliminary plans for such a conference, along with a statement of purpose and costs.

NEW COMMITTEE — The Council established an ad hoc Planning and Priorities Committee to develop guidelines and policies for Council deliberation and action.


In dermatologic disorders...

the
advantages
of
ALLERSONE
OINTMENT
in
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antiinflammatory
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IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE
OINTMENT
for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.

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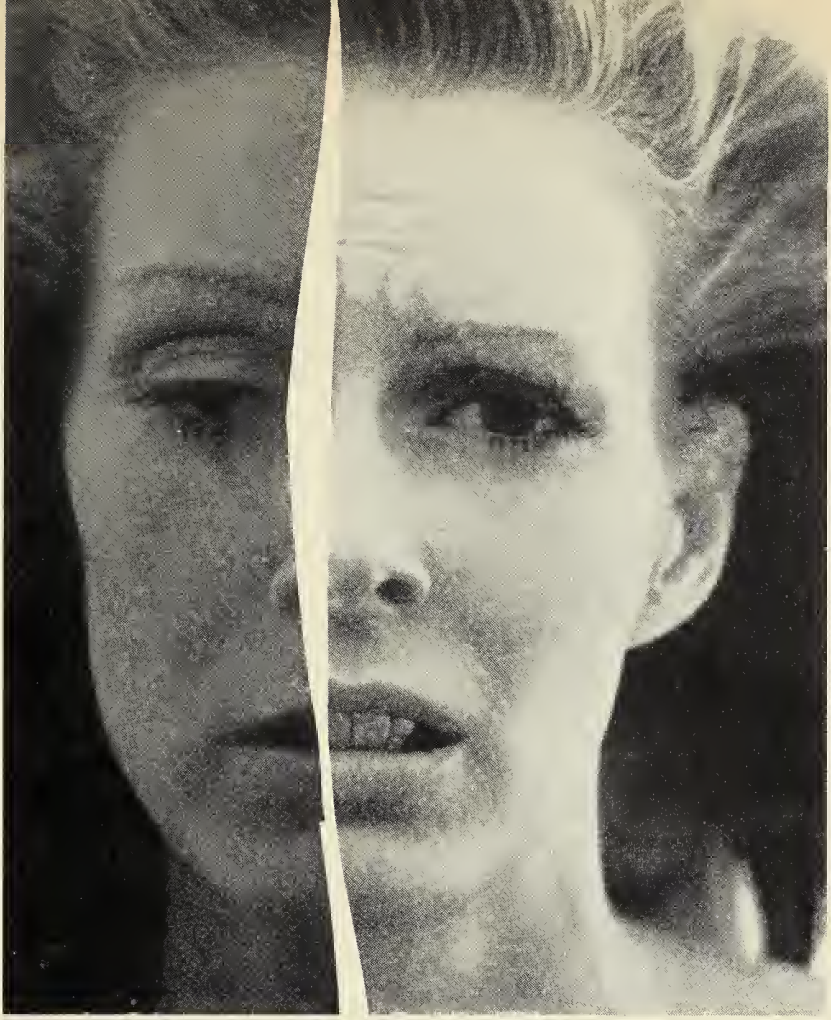

symptoms of mixed anxiety-depression are rarely clear-cut.

but they are often a clear indication for

Mellaril®
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25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

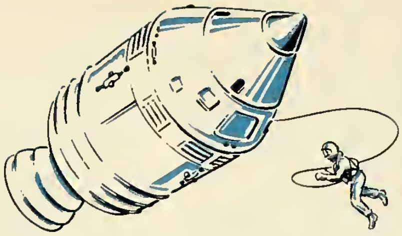
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

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medical care programs

BY HERBERT MEHLER
MSMS LIAISON
WITH GOVERNMENTAL AGENCIES

MICHIGAN COMPREHENSIVE HEALTH PLANNING ACTIVITIES

The Tri-County Hospital Facilities Planning group recently reorganized as the Jackson Area Comprehensive Health Planning Council, Inc. (Jackson, Hillsdale and Lenawee Counties) and has applied to be the officially designated health-planning agency. Considerable time and effort was spent to reorganize for expansion into allied areas of the health-care field, including environmental health and other para-medical fields. The 71 member Council was elected from a broadly-based group of constituent organizations involved in health-care to represent two categories: (1) professional and (2) public.

* * *

At the State level, the State Advisory Council formally recommended that the State Comprehensive Health Planning Commission adopt the following goals:

1. To achieve in this state the lowest level of infant mortality in the nation.
2. To achieve the highest state of nutrition in the nation among its infants and children.
3. To attain the highest available level of physical and mental health, including educational capacity among its children and youth.
4. To achieve the lowest incidents of ill health in the nation.
5. To achieve the highest level of health and productivity of Michigan citizens in the productivity phases of their lives.
6. To provide the highest possible quality of services and facilities for the well-being of aged persons.
7. To provide a healthy living environment for all citizens of the State.
8. To make adequate and efficient diagnosis and treatment readily available to provide comprehensive care to all Michigan citizens.

MEDICAID

A new division has been created in the Michigan Department of Social Services for the purpose of focusing sharp attention to the fiscal management matters of the Medicaid programs.

The new unit, to be known as Medicaid Fiscal Management Division, will be responsible for the management of all of the administrative and fiscal procedures that are a part of the Medicaid program. The division will serve as administrative liaison between the Department of Social Services and Michigan Blue Shield and Blue Cross, which serves as fiscal intermediaries.

* * *

MEDICARE—EXTENDED CARE BENEFITS

A portion of this program is the area of extended care benefits and, as a part of Medicare under hospital coverage, provides post-hospital care in an extended care facility that is an especially equipped skilled nursing home qualified to participate. The term "extended" refers *not* to *provision* of *care* over an extended period of time but to *provision* of *active treatment* as an extension of in-patient hospital care.

ECF care is just one level below the intensive care received in a hospital and is intended to relieve the burden on hospitals and to transfer patients to less expensive facilities at the earliest possible time. It is expected that a transfer to ECF occurs when a patient may still need skilled nursing care on a continuing basis but *does not require* the constant availability of medical services usually found in the hospital. Five requirements must be met for each admission:

1. Medical needs require continuing skilled nursing care — health care services which can only be provided by or under the supervision of trained medical personnel.
2. A physician determines that a patient requires extended care and so orders.
3. Patient must have been in a participating or otherwise fully qualified hospital for at least three successive days.
4. Patient must be transferred to the nursing home within 14 days after leaving hospital.
5. Patient must be admitted for further treatment of a condition for which he was treated in the hospital.

The need for skilled nursing care is periodically reviewed by the attending physician, the utilization review committee of doctors and professional care personnel and by the Medicare intermediary. When and if the patient's condition no longer requires such skilled nursing care, Medicare benefits for that portion of the program will end.

Social Security recently stated that the monthly Part B Medicare charge will be raised from $4 to "somewhat over $5" next July 1.

This would be the second boost in the monthly Part B fee since Medicare started (the original fee was $3). About 19 million people, or 95% of Medicare eligibles, are enrolled in Part B. HEW officials have until the end of the year to set the amount of the increase.

University of Michigan School of Public Health has received a one year grant of $54,685 from the Office of Economic Opportunity to train medical care administrators for neighborhood health centers throughout the country. Plans are being formulated to begin a series of institutes for persons currently employed in neighborhood health centers and to recruit and counsel students, primarily Negroes, to enter full-time training programs leaning toward administrative careers.

(Source: The University of Michigan, July 17, 1969.)

* * *

In November a brief article was devoted to the composition and functioning of the Grand Rapids Area-Wide Comprehensive Health Planning Unit (ACHPU). In this issue, the Capitol Area Comprehensive Health Planning Association (CACHPA) will be briefly reviewed as information for those seeking various suggestions and methods in forming an area-wide planning agency in their own area.

The purpose of CACHPA is to improve the quality, availability, and efficiency of physical, mental and environmental health services in the Tri-County (Ingham, Clinton and Eaton) areas by analyzing the health care needs, assisting and planning to fulfill unmet needs and to help develop facilities and services. The Association is currently funded on a one-year federal grant of $52,538 by HEW and approval of refunding for the second year in its developmental phase has been granted. Sources sought for local funding to match the federal grant include: Ingham County Health Department, industry, labor, banks, insurance, medical societies, hospitals and the Counties of Clinton and Eaton. The following committees have been formed: Executive, Medical Services, Planning, Facilities and Services, Manpower and Education, Environmental Health, Health Economics, Urban Design, and Nominating.

(Source: CACHPA Newsletter No. 1)

MICHIGAN DEPARTMENT OF SOCIAL SERVICES

A new division has been created in the Michigan Department of Social Services for the purpose of focusing sharp attention on the fiscal management matters of the Medicaid Program.

The new unit, to be known as Medicaid Fiscal Management Division, will be responsible for the management of all of the administrative and fiscal procedures that are a part of the Medicaid Program. The division will serve as administrative liaison between the Department of Social Services and Michigan Blue Shield and Blue Cross, serving as our fiscal intermediaries for the Medicaid Program.

MENTAL HEALTH PROGRAM AND STATUTE REVIEW COMMISSION

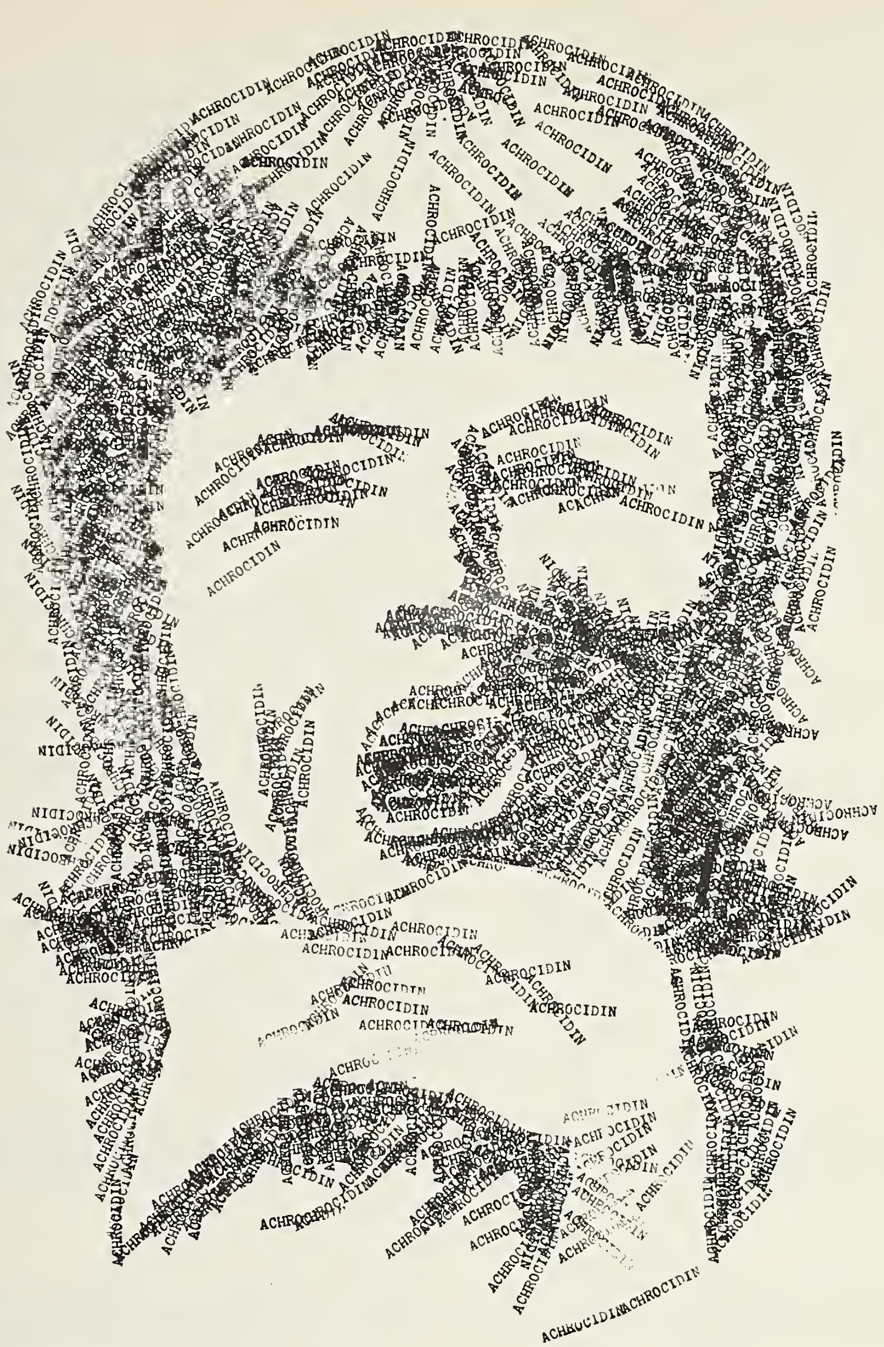
Appointment of members of this Commission was recently announced by Governor Milliken for the purpose "to review, analyze and recommend new language where needed, to modernize present mental health programs and statutes in conjunction with the Legislative Council Mental Health Program and Statute Review Committee." A major objective of the joint executive legislative effort is to develop laws to provide improved access to mental health treatment and the improved distribution of mental health treatment and the improved distribution of mental health services in the State.

MICHIGAN DEPARTMENT OF STATE

The Department was granted $5,000 by the Federal Highway Safety Agency to match a state appropriation as a first step towards creating a permanent Medical Advisory Board to advise the driver licensing authorities on the physical and emotional qualifications desirable for safe drivers. MSMS has long sought enactment by legislation but the State Legislature has not taken action despite the fact that legal creation of a medical advisory board is one of the requirements of federal standards for state action. The grant will permit the appointment by the Secretary of State of professionals to develop procedures and rules and possibly to pass on technical questions arising in the licensing process. Experts on vision and hearing, neurology, heart problems, metabolism, muscular and skeletal matters, drugs, alcohol, psychiatry, aging, obesity, mental retardation and fatigue will likely be appointed or act as consultants to the Board.

MICHIGAN OFFICE OF ECONOMIC OPPORTUNITY

Director Alton M. Shipstead has appointed J. Allen Beebe, III as deputy director. Mr. Beebe has been on the staff as executive associate since 1965. He received his bachelor of science degree in biology in 1942 and his master of science degree in public health in 1954.



Achrocidin® Tablets and Syrup

etracycline HCl—Antihistamine—Analgesic Compound

ich tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

CHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment f tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the pper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly tients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to etracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

ontraindications: Hypersensitivity to any mponent.

arning: In renal impairment, since liver toxity is possible, lower doses are indicated; durg prolonged therapy consider serum level eterminations. Photodynamic reaction to sunght may occur in hypersensitive persons. hotosensitive individuals should avoid expoire; discontinue treatment if skin discomfort ccurs.

recautions: Drowsiness, anorexia, slight gasic distress can occur. In excessive drowsiess, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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editorial viewpoints

Pickett's Charge

(Note: The following editorial is reprinted with permission from the Detroit Medical News, where it appeared in reply to a newspaper article reporting some views expressed by George Pickett, M.D., new Detroit city health director. — Brooker L. Masters, M.D., Publication Committee Chairman.)

BY JOHN W. MOSES, M.D.
SCIENTIFIC EDITOR

It is certainly marvelous, that after several years of difficulty in the health administration of Detroit and Wayne County under men of national repute, the department is now blessed with a director who has the answers (and 34 years of age, at that). George Pickett, M.D. states (*Detroit Free Press,* October 13, 1969) "The only justification for the hospital is that we failed to prevent disease in the first place." I agree, however, I would like Dr. Pickett's solution to atherosclerosis, coronary occlusion, diabetes, cancer, hypertension, pregnancy, birth defects, mental illness, benign prostatic hypertrophy, the ravages of age, and a myriad of others. When Dr. Pickett can give me the solutions to these, I will agree we need less hospital beds. What do you do, Dr. Pickett, when your patient cannot get into a hospital, because of lack of beds, for a simple herniorrhapy and must wait several weeks unable to work and earn for his family?

Dr. Pickett states "a health program run by the government is the long-run answer to health care problems not only in Detroit but in the rest of the nation." Is he implying that this has been successful for Detroit General Hospital, Herman Kiefer Hospital, the city and county health problems, the mental health problems at the local, state and national level? I seemed to have missed something somewhere, if this is the solution.

Dr. Pickett feels governmental aegis is the answer to our problems. He should study city and county hospitals and their problems, costs in V.A. Hospitals vs. community hospitals, and costs of the National Health System in the United Kingdom.

Dr. Pickett complains of the costs of the developing medical center in the central area. As I understand, the reason for the developing medical center is to develop a university complex capable of producing more doctors for the State of Michigan. As of January 1969, Michigan was 2,000 doctors short of our needs. Dr. Pickett states "the physician is not the key to health care." It would be interesting to ask a sick person if he agrees.

Dr. Pickett states "Recent studies in the inner city showed that 30% of the people who saw a physician on their own volition would have been better off if they stayed home. They were harmed by it. They were mismanaged." If Dr. Pickett can substantiate these allegations he owes it to the medical profession to clarify such statements and may even have grounds for presentation to the Ethics and/or Mediation Committees of the Medical Society, if he believes in such usage.

Dr. Pickett dwells on the deplorable state of emergency care in the city of Detroit. We concur. Wayne County Medical Society has in the past suggested, after a detailed study, solutions to the city. Either for lack of money or lack of guidance (or both) from governmental and health officials none of these suggestions have been acted upon. Rather, the city government has compounded the problem — e.g., their expertise in handling the mental emergency problems for the area.

Dr. Pickett states that physicians' incomes have "skyrocketed." Once again I seemed to have missed the boat. I would like to know the increase in costs of the City-County Health Program in the last ten years and what percentage of this is due to physician costs (actually paid — not budgeted).

Dr. Pickett suggests, throughout his press interview, the team approach to medical care. May I suggest to Dr. Pickett that he join the team.

'Getting Involved' May Hold Surprises

(The following article is reprinted with permission from the November *Bulletin* of the Kalamazoo Academy of Medicine.)

BY FREDERICK J. MARGOLIS, M.D.
KALAMAZOO

The eminent Walter H. Judd, M.D., writes in the August issue of *Michigan Medicine* that physicians must take a more active part in public affairs. This is a great idea since the physician can often lend a calm and dispassionate point of view to a nation presently in a state of social and political distress.

In the event that you decide to get involved in public affairs you may be in for a surprise even though the area of your involvement may be one in which you are expert.

Some of us have had such a surprise despite our knowledge of problems related to the current issue of sex education. We found a non-professional political action group crossing swords with us despite the need parents and young people have for help in this area. I am, of course, referring to our experience with the John Birch Society and the Christian Crusade and other allied right extremist groups.

Having had contact with these extremists at a half a dozen meetings in the last month, it is obvious that they are fear-ridden, fanatical and ignorant of the subject of sex education. Their whole fear-provoking pitch is to claim that sex education is at the level of the genitalia and sex in bed. Teachers are accused of putting children in dark rooms and telling them to go at it.

Anyone who opposes them gets the extremist treatment . . . you are either a communist or a tool of the Commie organization. We are in pretty good company since President Eisenhower, President Kennedy and Chief Justice Warren were among others so accused.

In his last major communication to the public, President Eisenhower wrote an article in the April, 1969, *Readers Digest:* WE *MUST* AVOID THE PERILS OF EXTREMISM. He points out beautifully how the Commies on the left and the Birchers on the right gain power by whetting the emotions of anger, fear, and hate. He states that these are nearly always the weapons of the extremists. His strongest statement is that the extremists are the people who cause *most of the trouble in the world.* He also points out that both extremes of the political spectrum are characterized by irresponsibility. We can personally verify that irresponsibility is the hallmark of the extremists.

It is reassuring that the American Medical Association has held firm in its position on sex education. The AMA recognizes its responsibility in helping young people develop mature, responsible, attitudes as their understanding of human sexuality is enhanced. Religious leaders have also recognized the need. The interfaith council representing Catholic, Protestant and Jewish leadership has taken a clear position on the validity of sex education. Many churches have developed excellent programs on their own.

In the event that some of you do decide to come out from under the reasonable, scientific, and protective umbrella of the professional community into the public arena, you may find yourselves involved in a shocking confrontation where ground rules do not exist and fanaticism prevails. It is an experience worth having if you want to participate in combating the extremist and preserving the democratic process. The opportunity is available to physicians in most every community in the United States.

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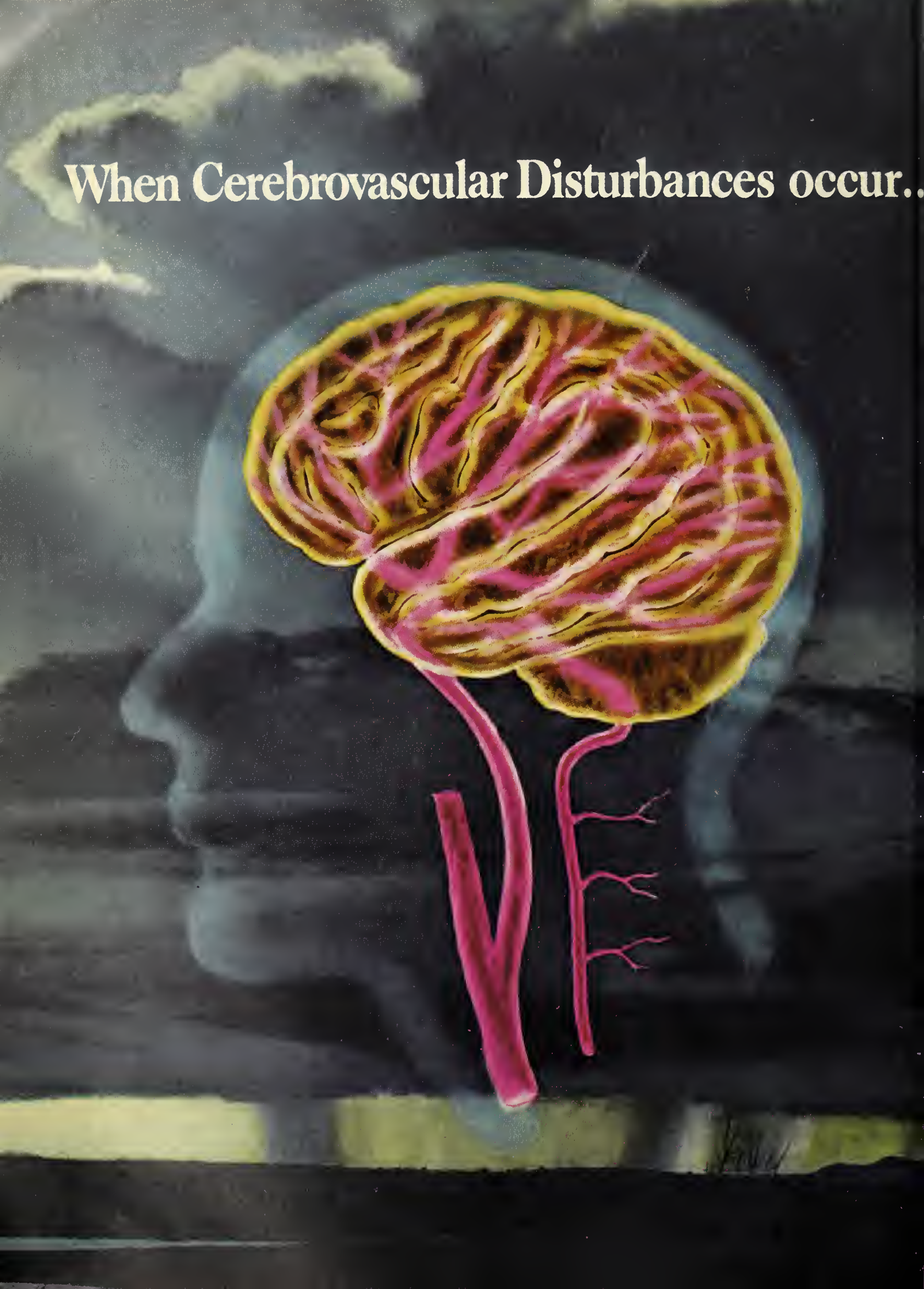
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Muskegon Survey 'Prejudiced,' Charges Michigan Blue Shield

BY NEAL McCUE
VICE PRESIDENT, PROFESSIONAL RELATIONS
MICHIGAN BLUE SHIELD

Michigan Blue Shield must ask to reply to the article in your November issue entitled "Muskegon Doctors Release Figures of Study of Their Relationship with Blue Shield."

Blue Shield questioned (privately) the validity of the design and the accuracy of the methods of this study when it was in progress. Now that it has been publicized, we must challenge its conclusions and inferences as obvious violations of accepted research practices, reflecting the often expressed bias of certain more vocally negative leaders in the survey area.

HOW BIASED and how negative can one be? The "President's Message" in the April, 1969 *Muskegon County Medical Society Bulletin* set the survey stage by use of astonishing language in comparing the disapproval which Jesus Christ voiced with the "establishment" of His time to that of Muskegon physicians with Blue Shield. George Washington, Martin Luther King and Abraham Lincoln were worked into the same paragraph in similar comparisons.

The April message, which shows prejudgement by its publication before the survey was begun, accused Blue Shield of "dictatorial power," and said we had entered into "a program of harassment of the non-participating physician."

It called us "enamored" of our own righteousness, accused us of some bosomy smothering of the individual physician and continued in such vein.

Remember that the survey had not been started. Yet, the message said that the survey would supply "an arsenal filled with facts" to discredit Michigan Blue Shield.

ONE MUST also consider in weighing the *Michigan Medicine* article that the conclusions and inferences drawn therein come from an artificial response from the physicians of Muskegon County. That is because the sample was heavily skewed by disproportionate representation of non-participating physicians.

When one wades through all of the calculations, all of the percentages of response and non-response, we come to the simplicity of the fact that the County Society sent its biased questionnaire to 107 doctors, that it obtained responses to *some* of the questions from 61 persons (or 57 percent), that only 11 of those responding were participating physicians.

Ignoring the editorial exclamations of the article, it is obvious even in old math that the response is not representative of the opinions of the physicians of Muskegon County.

There were 56 of Muskegon County's 115 physicians of record participating in full with Michigan Blue Shield, or 49 percent, in April, when the study was begun. The study says 11 participating physicians responded. That means that 45 did not.

And 45 is about 42 percent of the total of 107 respondents. Take away such a percentage, and how accurate can be your answers? This is like conducting a political poll in which Republicans do not participate.

WHILE BLUE SHIELD does not mean to impute in any way that physicians who do not formally participate automatically disapprove of this organization, it does remain that a formal participant is more likely to have a favorable attitude toward us. And it follows, again, that a survey which excludes the opinions of such persons is not representative.

This is not to say that participating physicians are fearful of voicing their opinion, but it is reasonable to suggest that when a person receives such a questionnaire from a colleague in a position of influence, and one concerning an emotion-filled area of controversy, a prudent person may choose, simply, not to answer. He joins a "silent minority," if a substantial one, and he is not counted.

Nor does Blue Shield intend to impute automatic disapproval in any way to the per-case participating physicians. Certainly the fact that use of pay-physician forms has risen from 72 to 92 percent in the states since the advent of the Michigan Variable Fee program indicates general acceptance of the payment range. It is interesting to note here that, even in the survey, only 25 Muskegon physicians said they did not participate on at least a per-case basis.

WE MUST acknowledge confusion as to the article's calculation that only 11 percent of patients received "the benefits of physician participation" if both formal and "per-case" participation are considered.

It would appear that this strange conclusion was drawn from, again, a non-representative sample, this time of only 50 physicians.

That is, it would seem so from the *Michigan Medicine* article. When we go back to the questionnaire itself we find, among the confusion of what the article itself calls "non-sequiters" in arithmetic, that there were really 59 (of 107) physicians counted in the questions about such benefits, but that 15 of the 59 did not answer the questions in any way. These 15 appear to be added, by the author, to the 22 physicians who *said* they did not participate.

Michigan Blue Shield is puzzled, yes, dismayed, at such juggling of figures and questionable extrapolations. It is typical of the occlusion of all positive reference in the study.

Since we are forced to question the basic statistics of the survey, a point-by-point rebuttal is not only of little value but becomes ludicrous.

THERE ARE TWO curious tables of statistics displayed in the article. One is an analysis of an unidentified group of 18 doctors who list unpaid Blue Shield accounts ranging from a delay of none to 150 days. The other is an analysis of billings by a single physician and another unidentified group.

We shall be pleased to inquire into these when more information is furnished. Certain obvious answers suggest themselves, but it is pointless to inquire into them here.

It is axiomatic in the survey field that a study is no better than its sample, that it should be done by neutrals, that it can not use leading or intentionally negative questions or involve generalizations and that it must have a statistically valid response.

Michigan Blue Shield considers the survey prejudiced and of, at best, curiosity-arousing value. It is not professional in the research sense, not representative and not responsive to the serious difficulties which confront us all today.

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The Question of Incorporating

BY JUDITH MARR
MANAGING EDITOR

Would a professional corporation be a wise move for me?

Many a Michigan physician in private practice has been asking himself that question, particularly in the light of much recent discussion of professional corporations by the U.S. Congress.

It is a difficult and complex question, with many elements to be considered. But some excellent thoughts on the subject have been expressed lately. And, as a service to Michigan physicians, MSMS offers the following resume of the debate, as well as the progression of Congressional rulings which have fed the fires.

Latest Development In U.S. Senate

Most recent action of Congress has come from the Senate, which, after much deliberation, on Dec. 9 finally killed a recommendation by its Finance Committee. The committee proposed that the Tax Reform Act of 1969 (H.R. 13270), which has already passed the U.S. House of Representatives, include a provision which would limit Professional Service Corporations formed under state laws to permit each executive the same allowable dollar maximums of tax-free income to be set aside in a retirement plan as are permitted by the Keogh Act for a self-employed individual.

Under the Keogh Act. (HR 10), self-employed individuals may defer tax on $2,500 per year or 10% of earned income, whichever is less, until the retirement of the person (s) covered by the plan.

MSMS and the AMA were prominent among those urging the original adoption by Congress of the Keogh Act, designed to bring to the self-employed benefits more closely approximating those available to corporate employees.

The Michigan Association of the Professions (MAP) was similarly active and, in Michigan, also worked closely with MSMS in securing passage of the Michigan Professional Service Corporation Act of 1962 by the state legislature. Pending further improvement of the federal Keogh law, the 1962 act provided an even more equitable opportunity for professional persons in Michigan to develop adequate retirement programs for themselves and their employees.

Michigan was one of the pioneer States in permitting professional service corporations for pension and tax reasons. About one-half of the 1,400 professional corporations established in Michigan have been founded by M.D.s. Now more than 40 states have such laws.

In 1968, the AMA Judicial Council ruled that it is ethically permissible for Doctors of Medicine to form professional service corporations.

Non-Tax Advantages Of The P.C.

During the 1969 MSMS Annual Session, MSMS Legal Counsel A. Stewart Kerr discussed professional service corporations in great detail, and a copy of his talk appeared in the November issue of *Michigan Medicine*. Covered were the non-tax advantages of such an organization, the tax advantages and the problems presented by professional corporations.

Among the non-tax advantages, Mr. Kerr listed:

1) A Professional Corporation (P.C.) has, to some degree, the attribute of limited liability.

2. P.C.s have other corporate characteristics such as continuity of existence, free transferability of ownership of shares and continuity in holding title to property, as well as centralized management.

3. P.C.s involve certain formalities such as keeping of orderly records and minutes and therefore can be a utilitarian vehicle for conducting business affairs.

4) P.C.s are more manageable in connection with estate planning and probate matters than are partnerships and proprietorships.

5) P.C.s do not terminate, as do partnerships, on the death, retirement or addition of a member.

"The primary benefits of practicing medicine as a P.C. involve the tax benefits to employees from pension and profit sharing plans," said Mr. Kerr. "These benefits are available, of course, only if the principals involved decide that they

(Continued on Page 60)

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are willing to defer income to later periods. If you intend to withdraw all the income from the operation in current salaries, these pension benefits would be of little or no consequence and one of the chief advantages of P.C.s would be missing."

Tax Advantages Of The P.C.

Among the tax advantages, Mr. Kerr included:

1) Employees of P.C.s can benefit from pension and profit sharing plans. The more important are that a) there is an immediate tax deduction for the P.C. for its contributions to the plan so that the actual cost (based on a P.C. in the 52.8% post surcharge bracket) will only be $.47 per dollar contributed; b) if the pension plan is funded by life insurance the premiums are, in effect, deductible expenses; c) the pension trust is, itself, exempt from tax and it can accumulate income much more rapidly than can an entity subject to income tax; d) there is an estate tax exemption on survivorship benefits if received from a qualified plan.

2) Corporate employees may receive payment from accident, health and sickness insurance plans tax free where the insurance is paid for by the P.C.

3) P.C.s may adopt medical expense reimbursement plans which, in substance, permit the deduction of medical expenses without the 3% limitation.

4) P.C.s may adopt wage continuation plans whereby the costs paid directly by the P.C. or paid as a premium for disability insurance are deductible by the P.C. and the benefits received by the disabled employee (subject to certain limitations) are excluded from his income.

5) The benefits from group term life insurance plans are tax free to the employees.

6) Employees of P.C. receive the benefit of social security premiums tax free.

7) Employee death benefits to P.C. employees up to $5,000 are exempt from tax.

8) P.C.s have free choice of a fiscal year.

9) P.C. employees may obtain benefits of deferred compensation plans which can be spread or may postpone income to later years.

10) Stock options and stock bonuses are available to corporate employees.

11) P.C. income is taxed (before accounting for the surcharge) at the rate of 22% on the first $25,000 of income and at the rate of 48% thereafter. However, corporate income is theoretically taxed "twice" when distributed as dividend income.

12) P.C.s are allowed to deduct 85% of the dividends which are received from other domestic corporations. Thus, without taking into account the surcharge, the effective rate on dividends received from other corporations is only 7.2% when the corporate rate is 48%.

Non-Tax Problems Of The P.C.

"P.C.s do present a number of problems," Mr. Kerr noted. "Most of their disadvantages can be avoided by careful advanced planning." Major problems which may arise include the following:

1) The possibility of a surtax on accumulated profits over $100,000. The solution of this problem is simply not to accumulate that much or have a good business reason for doing so.

2) A deduction for "unreasonable" compensation may not be allowed. To justify the deduction, salary income must be earned; otherwise any portion of "compensation" will be deemed to be a non-deductible dividend by the corporation.

3) There may be a taxable transaction at the time of the organization of the P.C. if it is not a transfer to a so-called "controlled corporation"; that is, if the individuals owning the property transferred to the P.C. do not end up owning more than 80% of the new corporation.

4) There may be, at the time of incorporation, a tax on the unrealized receivables transferred to the new P.C. This may be avoided by keeping the old partnership alive until those items are collected; otherwise, there may be serious bunching of income."

In early August of this year, the Internal Revenue Service finally, after a long fight, decided to recognize professional corporations formed under state laws similar to Michigan's as "corporations for tax purposes." This action sparked considerable increased activity and interest in the forming of such corporations.

In essence, although the IRS action thus does permit the incorporator(s) a substantial break in having the tax on pension plans deferred until retirement (as explained in the Kerr article), the fact remains that all of the Michigan general corporation laws, and all of the IRS rules applying to corporations, subscribe such a form of organization.

Then the Senate Finance Committee, in considering the already House-Passed Tax Reform Act of 1969, recommended that these tax benefits be denied to professional corporations.

The American Medical Association mounted a vigorous effort to defeat the U.S. Senate Finance Committee recommendation and its constituent state medical societies were requested to lend all possible assistance.

(Continued on Page 67)

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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the dru should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk t minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derma-

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kness may occur and require
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1. Agranulocytosis can occur
ldenly in spite of regular, repeated
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l, rarely, salivary gland enlarge-
nt may require cessation of treat-
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definitely attributable to the
g, a causal relationship cannot
be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily. In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-C

For complete details, please see full prescribing information.

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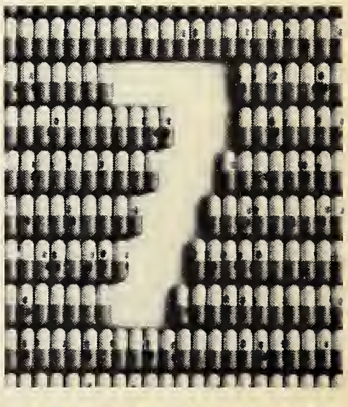

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Dulcolax suppositories may be particularly helpful when straining should be avoided, as in postoperative care. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

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MSMS Opposing Senate Recommendation

In the November News Extra issue of *Michigan Medicine,* Legislative Counsel Riley observed: "MSMS concurs that since every professional person should have access to equal retirement program opportunity, whether self-employed or not, two facts are clear: first, the states' Professional Service Corporations laws should not be forced into a parity with the federal Keogh Act; and second, the federal Keogh Act itself should be liberalized to substantially raise, or entirely eliminate, arbitrary ceilings."

The Michigan Association of the Professions interpreted the Senate Finance Committee's recommendation as "striking a deadly blow at the hundreds of professional service corporations which have been established under the several state laws permitting such corporations."

Continued MAP in its Nov. 12 newsletter "Compass":

"The major incentive for such professional service corporations has been that, as corporate employees, the professional people could enjoy more liberal pension benefits taxwise than they could when they operated as self-employed individuals or in partnerships. Further, under the professional service corporation, professional groups could set up equal percentage, profit sharing plans for both their professional and non-professional employees, thereby increasing their ability to hire and retain desirable employees. They were better able to compete with large business and industry for the type of personnel they so emphatically needed. This is particularly important today when the professional people are being asked to help shoulder increasing demands from expanding communities."

Before all the controversy broke over the Senate Finance Committee recommendation, *Physicians Management* magazine prepared for its November issue an article entitled "The Solo Corporation: Windfall or Pitfall?"

The article dealt in detail with the pros and cons of professional corporations before the advent of the Senate Finance Committee's recent recommendation. Much of the article is still valid and offers good ideas for the physician considering incorporating.

Author Thomas E. Zirkle, vice president, Professional Management Associates, Inc., Oak Brook, Ill., and a member of the Society of Professional Business Consultants, pointed out that "experts now almost unanimously agree that a multi-doctor corporation which is well-conceived, which consistently adheres to basic concepts of corporate organization and practice, and which is constantly vigilant to avoid tax traps will be relatively safe from successful IRS challenge.

"Accordingly, those groups which can derive substantial economic benefit from corporate practice should be encouraged to incorporate, provided that they are willing to expend the money and effort to do the job properly and further provided that the individual members are mutually agreed

(Continued on Page 70)

county societies

WASHTENAW DOCTORS, AUXILIARY DISCUSS SEX, DRUGS

Five guest speakers, including three medical doctors, discussed "Sex Education and Drug Abuse" at a recent meeting of the Washtenaw County Medical Society and its Woman's Auxiliary. Speakers included Doctors George Lowrey, Stuart Finch and Carl Hug.

INGHAM PHYSICIANS, LAWYERS HEAR LIABILITY TALK

The Ingham County Medical Society and the Ingham County Bar Association held a joint meeting recently to hear Alfred S. Julien, New York City attorney, discuss "Modern Concepts of the Liability Affecting the Physician and the Hospital."

LENAWEE SOCIETY SUPPORTS COUNTY EMERGENCY SERVICE

The Lenawee Medical Society adopted a resolution recently urging the county board of supervisors to provide adequate funds and personnel to the sheriff's department for ambulance service. Sheriff Richard Germond spoke at the county society meeting, describing his efforts to serve the county with six sheriff's ambulances now that funeral homes have discontinued the 13 private vehicles they formerly operated.

SOUTHWEST MICHIGAN CLINIC FEATURES ANN ARBOR DOCTOR

The annual Southwestern Michigan Clinic at Battle Creek featured Edgar A. Kahn, M.D., Ann Arbor, who delivered the "Doctor Mustard Memorial Lecture." The day-long seminar also offered seven clinical discussions by specialists, and roundtable conferences.

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Number of patients	Mean initial value	Mean final value
14	3.23	4.83
16	3.50	4.40
25	4.52	4.47

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Precautions: Should not be used in patients with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations.
Side Effects: While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum.
Administration and Dosage: K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement.
How Supplied: Effervescent tablets—boxes of 30 and 250 (orange or lime).

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on procedures and objectives and that each doctor is satisfied that the impact on his personal life is tolerable," advised Mr. Zirkle.

P.C. No Panacea Before Latest Events

"In short," he added, "even with IRS opposition substantially removed, incorporation is not necessarily a panacea for every group."

Continued Mr. Zirkle:

"In assessing the probability of future IRS action, especially regarding one-man and other small corporations, it is necessary to briefly evaluate the IRS action (and lack of action) in the court cases which preceded the August 8 announcement (to recognize professional corporations formed under state laws 'as corporations for tax purposes.') First, it seems apparent that IRS decided to contest these cases solely on the merits of the IRS's controversial 1965 regulations which said, in effect, that professional corporations had inherent characteristics which disqualified them from corporate status under the accepted definitions of corporations. Second, the IRS did not assert a number of principles which might conceivably have been effective in some of the decided cases. Those principles, however, are essentially unrelated to the question of corporate validity and would be questions of fact in each individual case. The obvious conclusion would seem to be that the IRS focused its efforts on achieving a position in which it could successfully deny corporate status to all professional corporations without regard to individual circumstances. It wanted a clear-cut decision on this issue, unconfused by the presence of other issues. If successful in this effort, the advantage to IRS would have been enormous since it would have avoided the necessity of contesting each corporation on an individual merit basis.

"Having failed in this effort against multi-doctor corporations, it is entirely possible, if not probable, that the IRS will attempt to apply its regulations against one-man corporations on the theory that a one-man corporation would be much more severely pressed to demonstrate the corporate characteristics of centralized management, continuity of life, free transferability of interest, and limited liability. Some attorneys argue that these tests are inapplicable if the corporation is valid under state statute while others firmly believe that one-man corporations will have to satisfy IRS standards. The latter group also believes that the IRS has a reasonable chance to make their case stick against the one-man concept.

"Beyond the issue of corporate validity, however, the IRS has available several well-established statutes in the Internal Revenue Code (which are well supported by case law) which present a very serious threat to any small corporation, particularly those involving personal services. By inference, the smaller the corporation the greater the exposure, with the one-man corporation thus being the most severely exposed.

"For example, Code Section 482 permits IRS to assert that income from personal services should be allocated (and become taxable) to the individual rather than to the corporation. . . . Since virtually all of the income in most professional practices is derived from personal services the threat here is obvious and genuine.

"Parenthetically, it should be pointed out that a major misconception is the emotional argument that since the IRS presumably doesn't harass other small corporations on these matters — say, a shoemaker, barber, etc. — why should they harass a professional corporation? The answer is simply a matter of potential revenue. Since IRS doesn't have the resources to challenge all transgressors, it focuses on the potentially more rewarding taxpayers — a category which will include professionals.

"Code Section 401 (a) provides, in part, that a qualified retirement plan must be for the exclusive benefit of the employees. If a clear differentiation cannot be established between an individual as employer and employee, deductions for contributions to a retirement plan may be disallowed. In a corporation with one stockholder, it may be very difficult for the doctor to establish that he is an employee rather than an employer, or both.

"Code Section 269 prohibits the acquisition of a corporation by an individual or individuals where the principal purpose is the avoidance of tax. A relatively large professional corporation would not normally be vulnerable to this problem; however, a small corporation may have difficulty showing convincing business purposes other than tax avoidance.

"Successful assertion of any of these three issues would effectively emasculate the economic benefits of corporate practice. Several other potential tax problems which might plague a professional corporation are: (1) Unreasonable compensation of employees — Code Section 162, (2) unreasonable accumulation of surplus — Code Section 531, (3) personal holding company status — Code Section 542, (4) collapsible corporation — Code Section 341, and (5) assignment of accounts receivable. Most of these problems can be avoided with skillful planning and by a temperate approach to tax matters by the corporation.

"In spite of these multiple and serious obstacles, many solo doctors are receiving indiscriminate ad-

(Continued on Page 73)

Painful night leg cramps...

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One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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So even in complex cases, the treatment can remain the same. Comprehensive. Effective. Easy as AVC/D.

Contraindications: Known sensitivity to sulfonamides; diagnosis or familial history of carcinoma of the genital tract or breasts; precarcinomatous lesions of the vagina or vulva; palpable uterine fibromyoma; mammary fibroadenoma; depressed liver function.
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Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: 'AVC/Dienestrol Cream'—Four ounce tube *with* applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 *with* applicator.
References: (1) Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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AVC/Dienestrol
Cream (dienestrol .01%, sulfanilamide 15.0%, aminacrine hydrochloride 0.2%, allantoin 2.0%)
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vice to proceed with incorporation. Some of the rationale advanced for this aggressive posture includes: (1) the doctor has much to gain and virtually nothing to lose, (2) the chance of corporations now being organized of having to litigate the issue of corporate validity is remote, and (3) the IRS, having lost one round already, will not further pursue professional corporations or (alternatively) there will be so many solo corporations that the Service will not be capable of effectively challenging them.

"The thinking in argument (3) appears to be more wishful than realistic.

Chance of Conflict With IRS Not Remote

"It is admittedly improbable that a doctor who incorporates now will have to go to court to establish the validity of his corporation. However, the chance of conflict — either audit and prolonged negotiation or litigation — with the IRS on the other issues previously listed is not at all remote. In fact, I firmly believe that the one-man corporation must recognize and accept the strong possibility of a relatively costly, time-consuming controversy which may result in a total loss of all economic benefits.

"The solo incorporator will experience a wide variety of costs, some of which will be relatively minor. Start-up costs will include (1) legal and accounting fees, (2) filing, charter, and licensing fees and (3) administrative costs for records changeover and possibly for actuary or contract fees if a pension plan is used. Increased operating and maintenance costs will include accounting and legal fees, taxes (franchise and payroll), trustee and/or administrator's fees and employee benefit programs. Other possible costs would be legal and accounting fees in the event of prolonged audit or litigation, interest on deficiency assessments, and significant losses of Keogh benefits in the event of total failure of the corporate program.

"These costs are not insignificant, even considering that most are tax deductible, and it is clear that failure of a one-man corporation would result in substantial losses. Plainly, the 'everything to gain, nothing to lose' approach is simply not valid, particularly considering that one doctor must bear the entire burden.

"In evaluating relative risk, my firm and our attorneys believed some five years ago that certain selected groups could incorporate with a good chance of success and with minimal expectation of conflict with IRS. Events have proved this evaluation to be correct and it is apparent that

(Continued on Page 74)

FIFTEENTH ANNUAL

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about doctors

PAUL KILMER, M.D., REED CITY,
was honored at a community open house at the high school recently in appreciation of his many years of service as a physician and school board member.

DEAN P. CARRON, M.D., ANN ARBOR,
is now regional vice president of the Family Service Association of America. He will preside over the Central Regional Council, consisting of representatives of 50 family service agencies in four states.

HERBERT ROBB, M.D., BIRMINGHAM,
discussed "Facing Death with the Aged" at an Oakland University conference recently on geriatrics.

JAMES R. JEFFREY, M.D., BATTLE CREEK,
is being honored by the Battle Creek Sanitarium Board of Directors which has decided to name the new hospital building for Doctor Jeffrey, who has been associated with the hospital for 47 years.

DANIEL LANDRON, M.D., MICHIGAN CENTER,
was honored recently at a community dinner for his 24 years of medical service to the community. He recently joined the emergency medical staff at Foote Hospital in Jackson.

WILLIAM BURNS, M.D., ALGONAC,
was recently named an "Outstanding Citizen" by the Algonac City Council for his civic-improvement activities.

L. C. KRAFT, M.D., LESLIE,
directed the rescue work recently to help free a driver who was trapped when his car skidded off US-127 near Jackson and overturned. *The Jackson Citizen Patriot* praised the efforts of the physician and other volunteers "to save the life" of the driver.

A. JAMES FRENCH, M.D., ANN ARBOR
recently was named secretary-treasurer of the College of American Pathologists. Now a member of the College's executive board, he has been a member of the Board of Governors for five years. Doctor French is chairman of the U-M Department of Pathology.

similar groups who proceed properly now are even more certain of success. In short, the potential gain weighed against the risks made the gamble worthwhile.

"The one-man corporation, however, is another matter. We believe that such organizations are much more vulnerable now than groups were five years ago — that their chances of success are much poorer and their probability of conflict with the IRS much greater.

"In summary, I would offer two generalities: First, a group of doctors should strongly consider incorporating their practice if they are satisfied by thorough analysis that they can achieve substantial economic benefits, if they are satisfied that they can function harmoniously — individually and collectively — in their new business environment, and if they are willing to conduct their corporate business in a reasonable and disciplined manner.

"Second, a solo practitioner should seriously consider incorporation only if his combined circumstances (income, age, marital status, type of practice) are genuinely extraordinary. As an example, a single doctor in his 30s who earns over $100,000 a year might find the possible gains to be of such magnitude that even long odds are acceptable, particularly if he has the kind of practice in which technicians, therapists, nurses or other professional employees directly generate significant elements of income.

MSMS Outlook On the Debate

At the time this article went to press, the Senate had just killed its Finance Committee's recommendation.

MSMS felt it would have been manifestly unfair and discriminatory to professional people if the final result of debate between the U.S. House and Senate had been insistence upon the Keogh limitations on tax-free income that may be set aside by incorporated individuals for pension purposes.

But reason has prevailed and there will be no legal restrictions this year and no legislation in the field until the Treasury Department sends recommendations to equalize the tax treatment of all pension plans following study that is not expected to be completed for many months.

"Congress probably will not act finally on the matter until late next year at the earliest," estimated Ernest B. Howard, M.D., executive vice president of the AMA, in a telegram sent Dec. 11 to Hugh W. Brenneman, executive director of MSMS.

Doctor, after all we've been through together...

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bronchopulmonary infection
brucellosis
chancroid
diphtheria
endocarditis
genitourinary infections
gonorrhea
granuloma inguinale
listeriosis
lymphogranuloma
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osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
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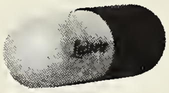

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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

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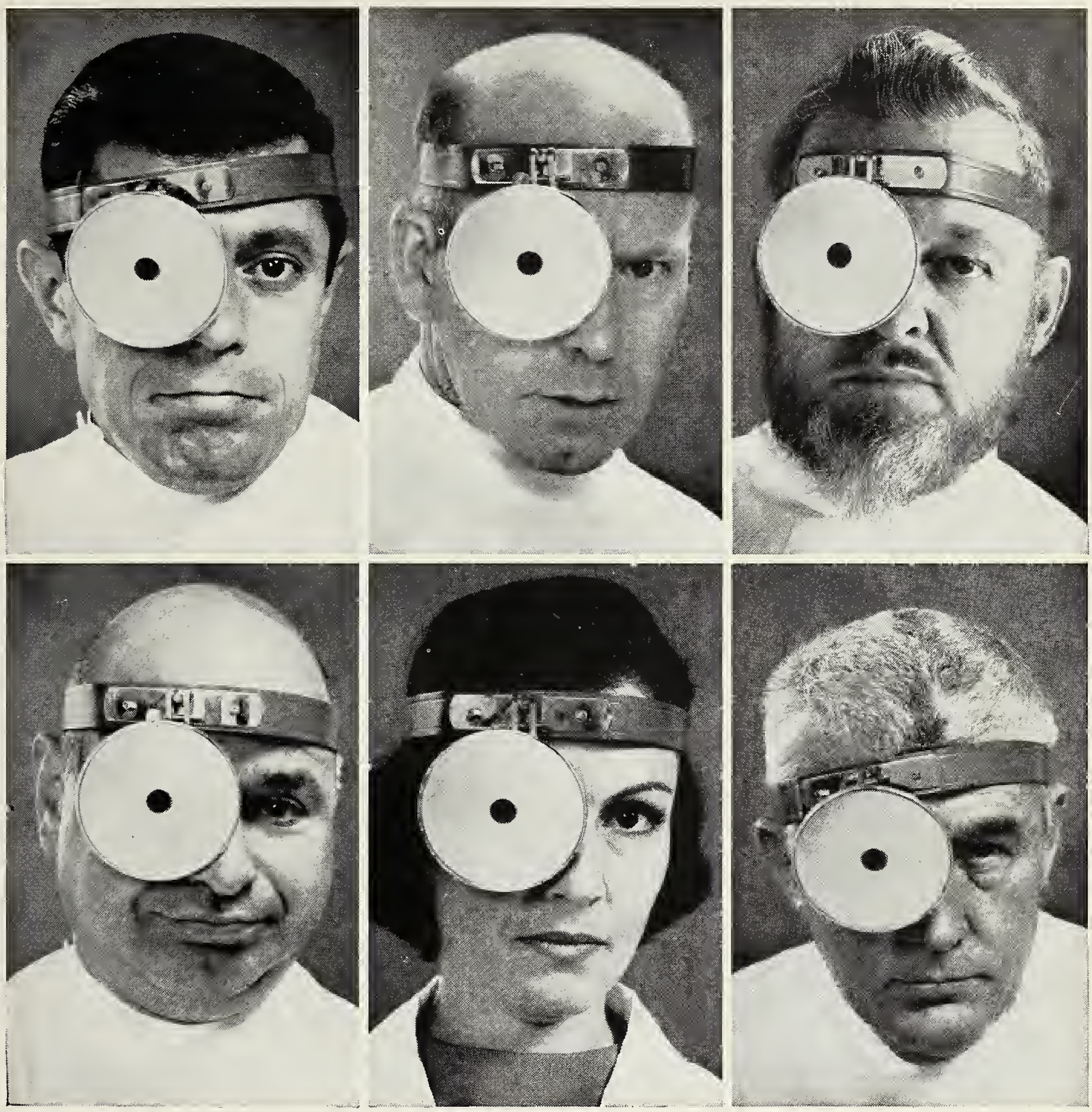
(Continued on Page 78)



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Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

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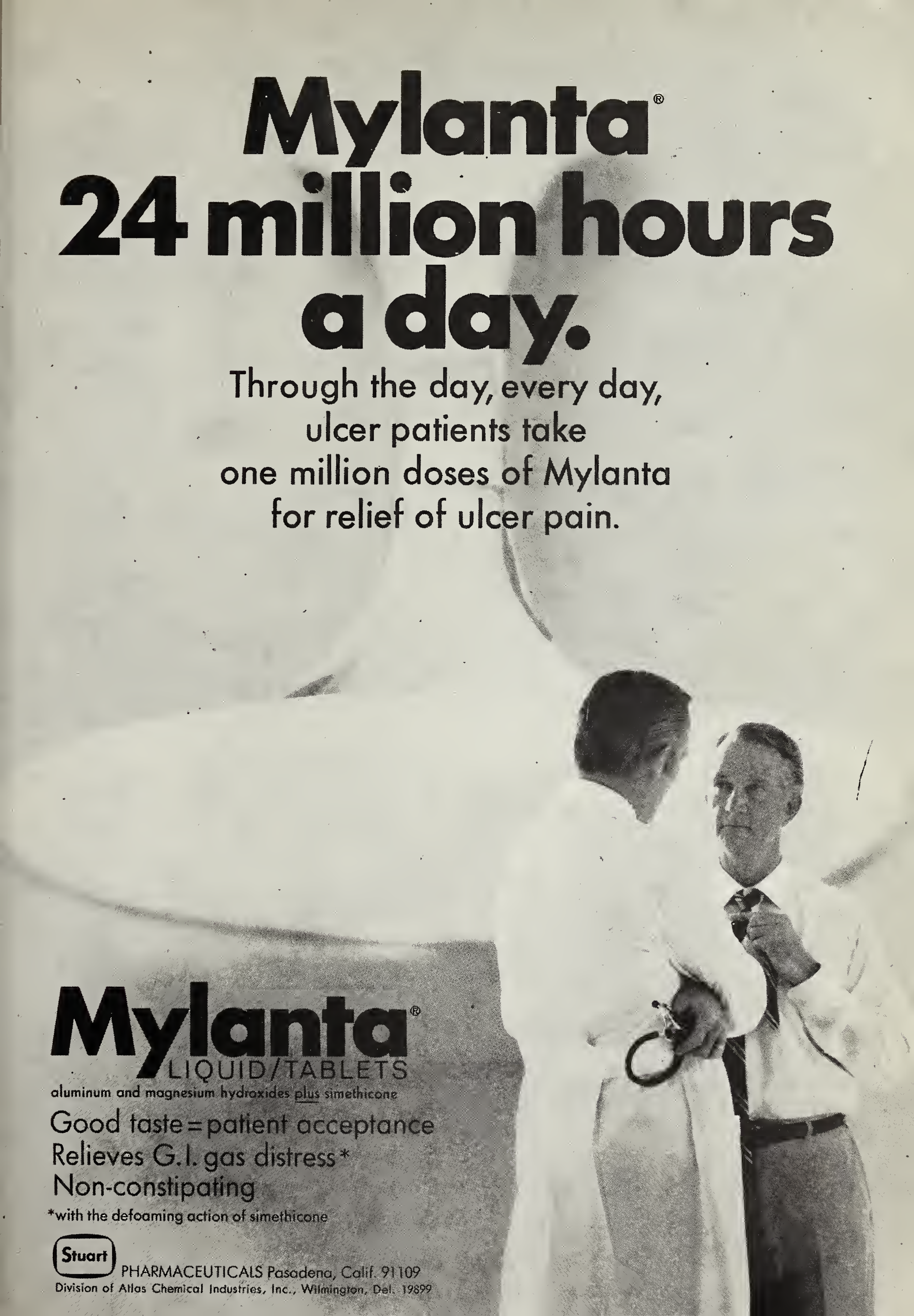

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In the article BELOW is a list of 142 Michigan communities seeking family physicians. AT RIGHT is a chart of 75 Michigan communities now registered as needing 1,400 specialists. Physicians seeking to locate in Michigan communities — and communities actively looking for physicians — are served through the MD Placement Service of the Michigan Health Council, 712 Abbott, East Lansing 48823.

Wanted - By Michigan Communities— 600 Family Physicians, 1,400 Specialists

As a service to the people of Michigan and the profession of medicine, the Michigan Health Council conducts the M.D. Placement Program under the guidance of the Michigan State Medical Society. Inaugurated in 1953, with less than 25 Michigan communities seeking assistance, the program has expanded rapidly as the need for doctors of medicine has grown. The Michigan Health Council currently has 142 communities that are seeking general practitioners. The list of those communities follows:

UPPER PENINSULA — Crystal Falls, Escanaba, Hancock-Houghton, Iron Mountain, Marquette, Menominee, Rock, Sault Ste. Marie, Stephenson, Stambaugh and Iron River, Mackinac Island, Norway, Newberry.

NORTH CENTRAL — Alpena, Atlanta, Boyne City, Charlevoix, Cheboygan, Gaylord, Grayling, Harbor Springs, Hillman, Lincoln, Mackinac City, Mancelona, Onaway, Posen, Rogers City, Traverse City, Vanderbilt, St. Helen.

WEST CENTRAL — Baldwin, Barryton, Bear Lake, Big Rapids, Carson City, Cedar Springs, Crystal, Edmore and Township, Eureka, Evart, Greenville, Hart, Holton, Howard City, Kent City, Lakeview, Manistee, Muskegon, Ovid, Ravenna, Reed City, St. Johns, Scottville, Shelby, Whitehall, Zeeland, Kaleva.

EAST CENTRAL — Bay City, Byron, Caseville, Cass City, Coleman, Columbiaville-Otter Lake Area, Essexville, Emmett, Flint, Gladwin, Goodrich, Hale, Lapeer, Lexington, Memphis, Metamora, Millington, Morrice, Mt. Pleasant, Pigeon, St. Clair, Sandusky, Sebewaing, Owosso, Saginaw, Deckerville.

SOUTHWEST — Albion, Bangor, Baroda, Battle Creek, Benton Harbor, Buchanan, Burr Oak, Charlotte, Coldwater, Eau Clair, Dowagiac, Grand Ledge, Hastings, Hillsdale, Jackson, Lawrence, Jonesville, Lansing, Litchfield, Marshall, Mason, Niles, Paw Paw, Napoleon, Allegan County, Potterville, Quincy, Sister Lakes, Reading, St. Joseph, South Haven, Sturgis, Tecumseh, Waldron, East Lansing, Three Rivers, Holt, Hudson, St. Joseph, (Ingham County.)

SOUTHEAST — Ann Arbor, Detroit, Madison Heights, Grosse Pointe Woods, Milford, New Haven, Pontiac, Romeo, Saline, New Baltimore, Milan, Monroe, Ypsilanti, Armada, Brighton (Livingston County).

Medical specialists also are in great demand in Michigan. Seventy-five Michigan communities now are registered with the Michigan Health Council's Placement Service, some needing only one additional specialist, others seeking several physicians in the same specialty and/or a wide number of medical specialties.

The Council currently is working with 38 communities that are seeking internal medicine specialists, 13 that are seeking psychiatrists and/or neurologists, 13 that are seeking surgeons and 28 that are seeking pediatricians.

For more information concerning the openings, write or phone John A. Doherty, Executive Director, Michigan Health Council, P.O. Box 431, East Lansing, 48823; Phone: 337-1615.

UPPER PENINSULA	Allergy	Anesthesiology	Dermatology	ENT	EENT	Immunology	Industrial Med.	Internal Medicine	Ob-Gyn	Occupational Medicine	Ophthalmology	Orthopedics-Orthopedic Surg.	Otolaryngology	Otology	Otorhinolaryngology	Pathology	Pediatrics	Public Health	Psychiatry & Neurology & Neuro. Surg.	Radiology	Surgery	Urology	Cardio-Vascular-Thoracic Surgery	Roentgenology
Crystal Falls								X														X		
Escanaba	X			X				X	X		X			X	X		X		X			X		
Iron Mountain																					X			
Hancock-Houghton				X				X	X			X					X		X			X		
Ishpeming-Negaunee								X				X					X							
Laurium																		X						
Marquette								X			X												X	
Menominee																				X	X			
Sault Ste. Marie					X			X	X		X						X				X			
Alger-Delta-Marquette																								
Com. Ment. Hea. Compact																			X					
Iron Mountain								X																
Stephenson-Daggett																X	X							X
NORTH CENTRAL																								
Alpena								X				X					X							
Charlevoix								X																
Cadillac		X						X									X							
Cheboygan								X									X							
Gaylord								X																
Grayling									X															
Traverse City																		X	X					
Lake City																		X						
WEST CENTRAL																								
Alma		X																						
Baldwin								X									X							
Greenville								X	X										X		X			
Hart								X																
Ionia State Hosp.																			X					
Manistee								X			X	X					X					X		
Muskegon												X						X	X				X	
St. Johns								X	X								X							
Spring Lake																								
Grand Haven																								
Ferrysburg												X												
Zeeland																					X			
Jenison											X													
EAST CENTRAL																								
Sandusky																		X						
Gladwin								X													X			
Goodrich																					X			
Lapeer								X									X							
Mt. Pleasant								X									X	X	X					
Owosso									X								X							
St. Clair								X																
Flint																		X						
Bay City			X					X				X			X		X							
Saginaw								X	X															
Midland																		X						
SOUTHWEST																								
Albion								X			X													
Allegan County								X			X						X	X						
Battle Creek								X											X					
Benton Harbor															X		X					X		
Buchanan																	X							
Charlotte																					X			
Coldwater				X				X	X			X					X				X	X		

(Continued on Page 82)

	Allergy	Anesthesiology	Dermatology	ENT	EENT	Immunology	Industrial Med.	Internal Medicine	Ob-Gyn	Occupational Medicine	Ophthalmology	Orthopedics-Orthopedic Surg.	Otolaryngology	Otology	Otorhinolaryngology	Pathology	Pediatrics	Public Health	Psychiatry & Neurology & Neuro. Surg.	Radiology	Surgery	Urology	Cardio-Vascular-Thoracic Surgery	Roentgenology	
Dowagiac																					X				
Cassopolis																		X							
Jackson								X			X	X													
Hastings								X									X								
Kalamazoo							X	X	X								X	X			X				
Lansing		X		X				X	X		X	X					X		X	X		X			
Marshall																	X								
Mason									X																
Niles					X			X				X													
Paw Paw								X										X							
St. Joseph										X			X				X		X						
South Haven									X								X				X				
East Lansing								X									X								
Allegan County																					X				
Hudson								X																	
SOUTHEAST																									
Ann Arbor																									X
Detroit							X	X	X																
Livonia								X	X																
Madison Heights				X									X				X								
Monroe				X								X	X						X			X			
Pontiac																		X	X						
Warren																	X								
Ypsilanti								X																	
TOTALS	1	3	1	6	2	0	2	38	15	1	9	12	3	1	3	1	28	13	13	2	13	8	2	1	1

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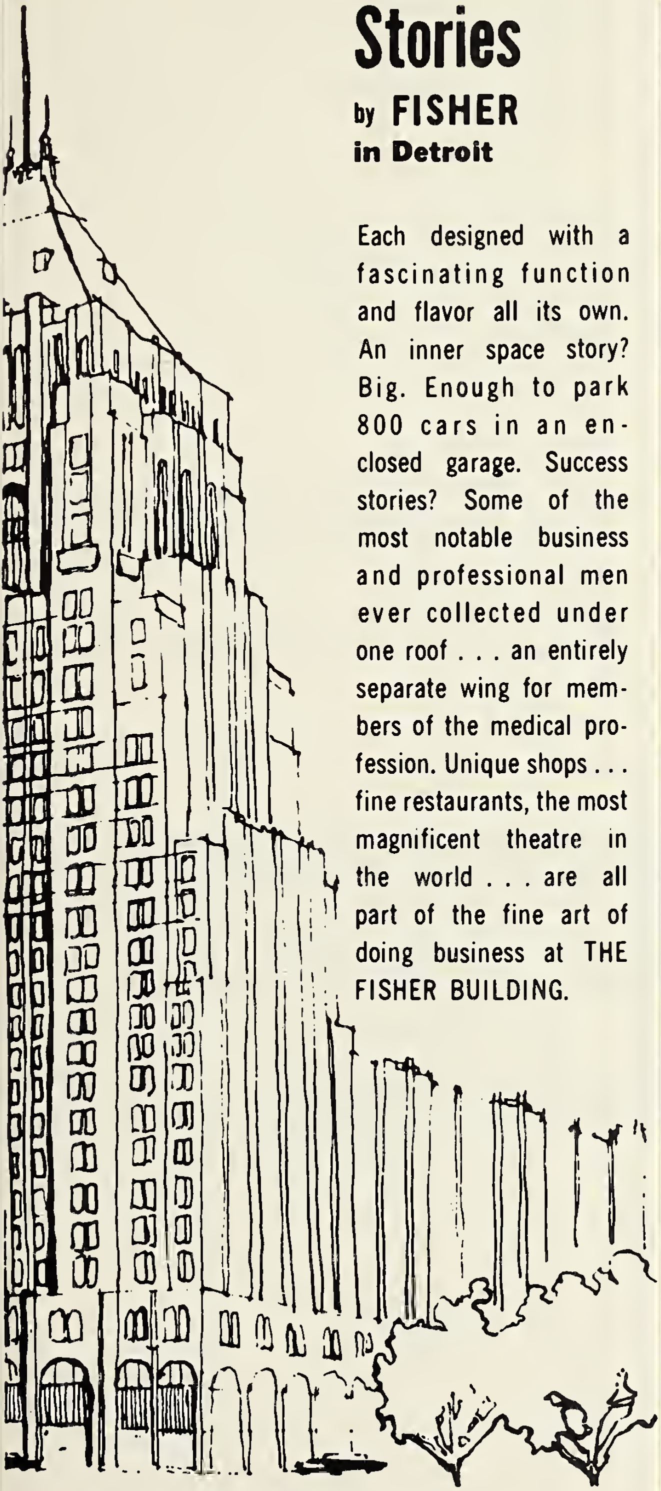
* 1904 - 1967



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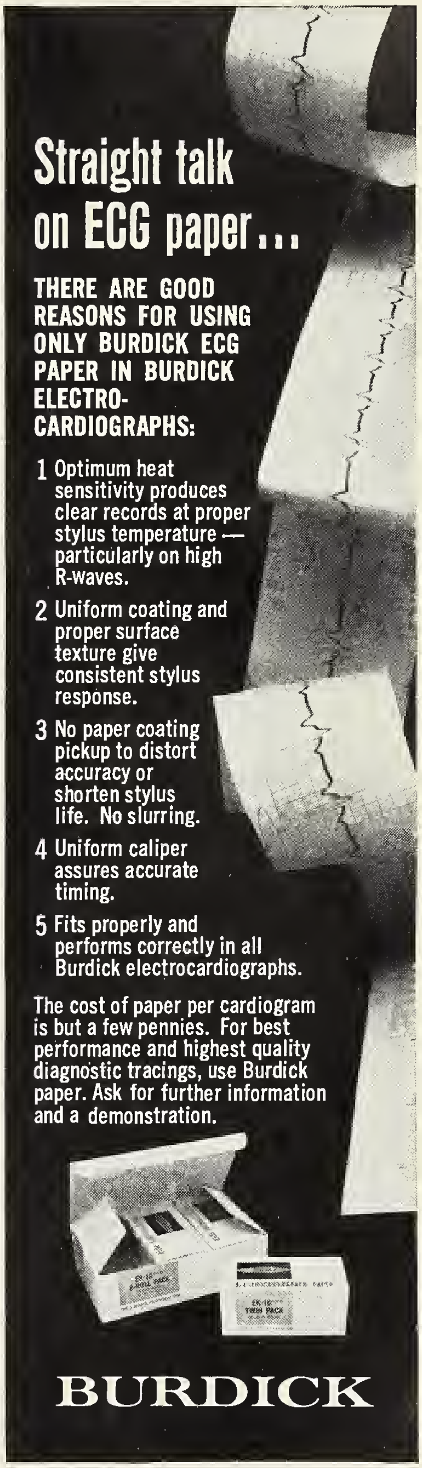

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in memoriam

Charles W. Balser, M.D.
Detroit

Charles Wadsworth Balser, M.D., retired Detroit physician who practiced 49 years, died Nov. 6 at the age of 80.

Doctor Balser had been affiliated with Detroit Memorial Hospital and was graduated from Loyola University School of Medicine.

George W. Christiansen, D.D.S.
Detroit

George W. Christiansen, D.D.S., internationally-known developer of techniques for maxillo-facial surgery and an associate fellow of the AMA Section on Laryngology, died Nov. 5 at the age of 75.

Doctor Christiansen, also an associate member of the Wayne County Medical Society, was holder of a number of national and international honors and was widely known for his work with servicemen who suffered shattering facial wounds during World War II.

He had been chief of oral surgery at the National Naval Medical Center at Bethesda, Md., and later served in the same capacity at Aies Heights Hospital in Hawaii.

Before his retirement in 1965, Doctor Christiansen was president of the Michigan State Dental Society, a member and president of the American Society of Oral Surgeons, a fellow of the American College of Dentists and a diplomate of the American Board of Oral Surgery.

He was attending oral and maxillo-facial surgeon to Detroit Memorial, St. Joseph's Mercy, East Side General, Deaconess and Saratoga General Hospitals, and senior consultant in oral surgery to the U.S. Marine Hospital.

James W. Hawkins, M.D.
Sarasota, Fla.

James W. Hawkins, M.D., Detroit Police physician until his retirement in 1963, died Nov. 5 at the age of 76 at his home in Sarasota, Fla.

Doctor Hawkins, a specialist in internal medicine, had been a member of the Wayne County Medical Society Council. He was a life member of the WCMS and was graduated from Wayne State University School of Medicine. He had served at the Mayo Clinic and New York Medical College.

Emery P. Kovach, M.D.
Grosse Pointe Farms

Emery P. Kovach, M.D., Detroit general practitioner, died Nov. 12 at the age of 62.

Doctor Kovach was affiliated with Doctor's Hospital of Detroit and was graduated from Wayne State University School of Medicine.

Ervin B. Moss, M.D.
Detroit

Ervin B. Moss, M.D., retired Detroit physician who specialized in industrial medicine, died Nov. 5 at the age of 66.

Doctor Moss had been affiliated with Detroit Memorial Hospital before his retirement in 1962. He was a graduate of the Wayne State University School of Medicine.

Dorsey W. Patterson, M.D.
Port Huron

Dorsey Webster Patterson, M.D., Port Huron physician for over 50 years, died Nov. 12 at the age of 79.

Doctor Patterson, who served as surgeon, radiologist and pharmacist for the Port Huron area, was honored in 1963 by MSMS for 50 years of practice. Also in 1963, he was one of four surviving members of the Class of 1913 to receive a Golden Anniversary diploma from Wayne State University College of Medicine.

Doctor Patterson had been a staff member since 1915 and former chief of staff of the Port Huron Hospital and was also affiliated with Port Huron's Mercy Hospital. He was St. Clair county physician from 1927-1932 and from 1942-1947. He was also St. Clair county health officer from 1928-1929.

William F. Reus, Sr., M.D.
Grand Rapids

William F. Reus, Sr., M.D., Grand Rapids physician for 26 years, died Nov. 24, 1969, at the age of 74.

A member of the Butterworth Hospital and St. Mary's Hospital Staffs, Doctor Reus was graduated from the University of Michigan Medical School. He was a founding member and on the board of directors of the American Association of General Practitioners, and also belonged to the Michigan Association of the Professions.

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Hans Von Brauchitsch, M.D.
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Index to Advertisers

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Brown Pharmaceuticals 85
Burroughs Wellcome & Co. 63
Campbell Soup Co. 37
Chicago Medical Society 53
Classified Ads 85, 86
Fisher Bldg., The 83
Geigy Pharmaceuticals 64, 65, 66
Glenbrook Laboratories 77
Henry Ford Hospital 86
Hynson, Westcott & Dunning 3
Ingram, G.A., Company 59, 83
Lederle Laboratories 10, 51, 75
Lilly, Eli & Co. 14
Mallard, Inc. 45, 46
Mead Johnson Laboratories 42, 43, 54, 55, 68, 69
Medical Protective Co. 57
Mediclinics 73
Mercywood Hospital 82
National Drug Co. .....Cover II, 71, 72
Parke-Davis & Co. 61, 62
Plainwell Sanitarium 78
Poythress, Wm. P. 48
Professional Management 87
Robins, A.H. & Co. 30, 40
Roche Laboratories .....Cover IV
Sandoz Pharmaceuticals 47
Searle, G.D. & Co. 38, 39
Stratton, Ben P. .....Cover III
Stuart Co., The 79
Wyeth Laboratories 8, 9

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BY HERB AUER, EXECUTIVE EDITOR

A publication, "Planning for Institutional Care of Children in Metropolitan Detroit," reports the results of an analysis of the programs of 19 voluntary Detroit child-serving institutions, includes the following statements:

"Drastic changes in cost of care have also occurred, arising partly from general increases in the cost of living. Cost increases also came as a result of the efforts of the institutions to better their ability to provide the type of services called for by the children they were receiving. As expenses increased and the total cost became greater, there was a comparable build-up of concern about the division of responsibility for financial support between contributed funds and funds from tax sources."

The Detroit study was sponsored by United Community Services of Metropolitan Detroit.

* * *

The American Management Association reports that "Since it costs as much as $50,000 to train a key executive, more and more companies are finding it prudent to sponsor free medical examinations for men in top management positions. Far too many executives with illnesses, real or imagined, put off seeing a doctor because 'they are too busy.'

"A key benefit to be reaped from these compulsory physicals is early diagnosis.

"When mandatory physicals were initiated, many executives expressed both resentment and doubt. However, most men are now convinced of their effectiveness."

In a recent article in the *New England Journal of Medicine,* Aug. 14, 1969, Paul Cushman, Jr., M.D., points out that sound arguments against tobacco are not new. He cites a 100-year-old study that indicates that smokers are less sharp academically than nonsmokers. The study, which was conducted at the Polytechnic School in Paris, summarized, in part, "Not only in the examinations on entering school are the smokers in a lower rank, but in the various ordeals they have to pass in a year, the average rank of the smokers had constantly fallen, and not inconsiderably, while the men that did not smoke enjoyed a cerebral atmosphere of the clearest kind . . . . . ." Recent findings on smoking and learning confirms the old study, says Doctor Cushman.

* * *

The Regional-Medical-Program-financed study of California physicians found that doctors in rural areas are generally more satisfied with programs of continuing education than are physicians in urban areas, regardless of their specialties. The programs presented on weekends generally appeared to be more successful and easier to attend than programs given at night.

Physicians in group medical practice said they are only slightly better able to attend programs than are physicians in individual practice; however, they are also somewhat less likely to find programs of interest.

A patient reports she wishes her doctor would say she was "Pleasingly plump" and stop saying she was "all flab and a lard wide."

* * *

The University of Arizona College of Medicine has a Division of Social Perspectives to explore medical — sociological changes. The division sponsors seminars for medical students "to stimulate tomorrow's doctors to think critically and thoughtfully about issues outside the classrooms." *Arizona Medicine* in the October issue describes the Division in an article "A New Approach in Educating Physicians."

* * *

The outlook for the future is so bleak — because even today half of the people in the world are not adequately fed or cared for, Georg Borgstrom, MSU professor of food science, told a meeting of the Food and Agriculture Organization of the United Nations in Rome recently.

We are facing a situation unprecedented in the entire history of the world, he said, explaining that, "more hundred millions of people will be added to the world in the next 10 years than ever before against a backlog of our having failed to adequately care for half of those now living."

Professor Borgstrom urged that "entomologists, plant pathologists, food scientists, geographers and ecologists need to be brought together not for fringe consultation but for meaningful, strategic planning."

* * *

Dwight L. Wilbur, M.D., president of the AMA, puts it neatly. Medical bills, he said recently in *The National Observer,* are resented because they require "payment for services people wish they did not need." They are enjoying what they pay for when they buy a car or a vacation, but "unfortunately, very few people ever enjoy the health care they undergo."

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Inside:

Ninth Annual Maternal Welfare Conference March 25-26, Flint

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Michigan State Medical Society
February 1970, Volume 69, Number 3

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Breaking News
January 1970, Volume 69, Number 2
Michigan State Medical Society

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Members, Chairmen Appointed To Major, New MSMS Committees

A total of 18 MSMS members have been appointed to two new society committees established for the purpose of better organizing the society and establishing its direction and goals.

James B. Blodgett, M.D., Royal Oak, speaker of the MSMS House of Delegates, and Ross V. Taylor, M.D., Jackson, chairman of the MSMS Council, have been named co-chairmen of a new joint task force to implement a professional management study and re-evaluation and reorganization of the society.

Brooker L. Masters, M.D., Fremont, chairman of the MSMS Publication Committee, has been appointed chairman of a new Committee on Planning and Priorities to develop guidelines and policies for Council deliberation and action, according to a directive from The Council at its Nov. 5 meeting.

Members appointed to Doctor Masters' committee are James B. Blodgett, M.D., Royal Oak; John J. Coury, M.D., Port Huron; H. F. Falls, M.D., Ann Arbor; A. C. McClay, M.D., Traverse City, and Milton R. Weed, M.D., Grosse Pointe Park.

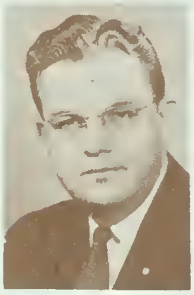
Members of the new Task Force are Sidney Adler, M.D., Detroit; Ralph R. Cooper, M.D., Detroit; John J. Coury, M.D., Port Huron; James D. Fryfogle, M.D., Detroit; Ernest P. Griffin, Jr., M.D., Flint; Harold H. Hiscock, M.D., Flint; Kenneth H. Johnson, M.D., Lansing; Robert J. Mason, M.D., Birmingham; Brooker L. Masters, M.D., Fremont, and John R. Ylvisaker, M.D., Lansing.

The task force's re-evaluation is to include consideration of (1) redefinition of purpose of the society, (2) refinement and streamlining of overall functions to conform to established goals, (3) headquarters and administrative changes to establish paid leadership with delegated authority to manage society affairs and to devise, institute and implement innovative programs, (4) study of restructuring state and county societies to combine forces, expand services, eliminate duplication, centralize and consolidate related activities and reduce total dues, and (5) establishment of direct member benefit or services programs of a tangible or cost-saving nature, and (6) streamlining of Council and committee activities.

Acting Director Appointed For State Health Planning Commission

Elena Padilla, Ph.D., formerly of New York City, has been appointed acting director of the State Comprehensive Health Planning Commission, to replace former Director Betty Tableman. Miss Tableman has no definite work plans, she reported Jan. 9. Doctor Padilla is former associate director of the National Institute of Mental Health Doctoral Training Program in Government and Mental Health at New York University, a position she held from 1963-1969.

Committee To Choose Successor To Dean Hubbard of The U-M



A committee will be appointed soon to consider a successor to William N. Hubbard, Jr., M.D., as dean of the U-M Medical School and director of the University Medical Center.

R. M. Boudeman, president of The Upjohn Co. of Kalamazoo, announced Jan. 13 that Doctor Hubbard will join the Upjohn Company on April 1 with responsibility for its pharmaceutical division. Doctor Hubbard has been a member of the Upjohn board of directors since December 1968.

U-M President Robben W. Fleming said, "Our very great regret at losing the administrative ability and wise counsel of Doctor Hubbard is eased in part in knowing that his talent will continue to contribute to the field of medicine and to Michigan through one of the state's leading enterprises."

Doctor Hubbard has been dean of the University's Medical School since 1959, and is a professor of internal medicine. He received his M.D. degree from New York University College of Medicine.

(A major article on Doctor Hubbard will appear in the February issue of *Michigan Medicine.*)

MSU Agrees To Begin DO School; Details Remain To Be Worked Out

Major points of establishing the first state-supported osteopathic college at Michigan State University remain to be worked out following agreement on basic principles of creating the school by officials of MSU and the private Michigan College of Osteopathic Medicine (MCOM) of Pontiac.

Yet to be decided are issues such as curriculum, the faculty and facilities, a timetable for establishing the new college and use of the Pontiac site. A number of additional meetings will be necessary before agreement on all issues is reached.

But "We agree that osteopathic instruction should begin at Michigan State as soon as funds, faculty and facilities can be made available and that each student now enrolled at MCOM will be guaranteed an opportunity to continue his education," said Jack Breslin. As executive vice president and secretary of MSU, he announced that consensus had been reached Dec. 31 following meetings of representatives of MSU, MCOM and the State Board of Education.

University officials had been given by the State Board until Jan. 1 to approve of MSU's designation as the site for establishment of the first state-supported school of osteopathic medicine. That was in accordance with Michigan Act 162 of the Public Acts of 1969, establishing such a college to be located "as determined by the State Board of Education at an existing campus of a state university with an existing school or college of medicine." MSU was so designated in late October.

Target Now Feb. 1 To Offer MSMS Umbrella Liability Insurance

Final requirements for approval of the umbrella liability insurance package for MSMS members were expected to be submitted the week of Jan. 12 to the Michigan Insurance Commissioner by the Employers-Commercial Union Group Insurance Company.

According to the Ben Stratton Insurance Agency of Lansing, agents for MSMS in drawing up the policy with the Employers-Commercial Co., the umbrella insurance should be ready to offer to MSMS members by Feb. 1. All MSMS members will receive information through the mails at that time.

Medicare Payments Raised; Blue Cross To Cover One Raise

The monthly premium for the voluntary part of Medicare (which covers MD fees and other medical expenses) will increase from $4 to $5.30 on July 1. These premiums, which cover half of the actual costs are paid by 19.3 million elderly.

The other half of the $10.60 monthly premium comes from general federal government revenues. HEW Secretary Finch, who ordered the increase, blamed his predecessor, William J. Cohen, for putting a drain on the program's reserves by not increasing the premium last year.

Payments required of Medicare beneficiaries for days of care in a hospital or convalescent facility were raised last fall. On Dec. 31, Michigan Blue Cross announced that for its 400,000 enrolled members it will automatically cover the increased Medicare deductible and coinsurance payments that began Jan. 1.

In Memoriam

Since the deadline for the January issue of *Michigan Medicine,* the following news has reached the MSMS office. Details will follow in the February issue.

Harry Arnkoff, M.D., Pontiac, 56, died Nov. 18.
Effie A. Arnold, M.D., Detroit, 82, died Nov. 19.
Lambertus E. Beeuwkes, M.D., Dearborn, 66, died Nov. 22.
L. Paul Sonda, M.D., Detroit, 73, died Nov. 24.
William R. Vis, M.D., Grand Rapids, 83, died Nov. 30.
John F. Sander, M.D., Lansing, 71, died Dec. 3.
Ray E. deSpelder, M.D., Detroit, 75, died Dec. 5.
Roy D. Tupper, M.D., Detroit, 77, died Dec. 9.
Norman D. Henderson, M.D., East Lansing, 51, died Dec. 10.
Edward L. Sager, M.D., Detroit, 74, died Dec. 13.
Allen E. Brunson, M.D., Sturgis, 60, died Dec. 14.
Edward T. Roth, M.D., Detroit, 77, died Dec. 14.

The following materials may be useful to you. Check any item (s) desired, cut out the form, and mail it in an envelope to MSMS, 120 West Saginaw, East Lansing, Michigan 48823. (Your address already is on the back of this same cut-out area of the page.)

_____**Booklet of Opinions and Reports of AMA Judicial Council, including AMA Principles of Medical Ethics and Rules of the Judicial Council.**
_____**Brochure describing the various AMA publications available for schools, churches, clubs, etc., about Sex Education, Drugs, VD, Drinking and Smoking.**
_____**Catalog from the Public Affairs Committee, NYC, listing publications dealing with Child Guidance, Generation Gap, Sex Education, Discipline, etc.**
_____**Booklet describing the services of the AMA Archives and Library available to AMA members.**

Maternal Welfare Conference Preliminary Program Now Complete

The preliminary program for the Ninth Annual Michigan Conference on Maternal and Perinatal Health has been completed. The conference, scheduled for March 25-26 at the Pick-Durant Hotel in Flint, will be sponsored by the Clara Elizabeth Fund of Flint and by MSMS.

Wednesday, March 25

"FETAL MALFORMATIONS CAUSED BY AMNIOTIC RUPTURE DURING GESTATION"

"DELIVERY OF MATERNAL AND CHILD HEALTH CARE"

"THE NURSE-MIDWIFE PROGRAM"

Speakers will include Roman R. Knoblich, M.D., associate pathologist, Hurley Hospital, Flint; Burris Duncan, M.D., instructor, Department of Pediatrics, University of Colorado; Mrs. Ann Smith, University of Colorado; J. Edward Hall, M.D., acting chairman, Department of Obstetrics and Gynecology, State University of New York Downstate Medical Center; and Miss Carmela Cavero, assistant professor, Nurse-Midwifery, College of Health Related Professions, Downstate Medical Center.

Wednesday Evening Banquet

"THE UNIVERSITY ROLE IN THE DELIVERY OF HEALTH CARE"

Harry Prystowsky, M.D., professor and chairman, Department of Obstetrics and Gynecology, University of Florida College of Medicine.

Thursday, March 26

"MATERNAL TISSUE REGISTRY QUIZ"

"THE TREATMENT OF RESPIRATORY FAILURE IN THE RESPIRATORY DISTRESS SYNDROME OF THE NEWBORN"

"FETAL DISTRESS"

"INTENSIVE CARE OF MOTHER AND CHILD"

Speakers will include A. James French, M.D., professor and chairman, Department of Pathology, University of Michigan; Paul R. Swyer, M.B., M.R.C.P., The Hospital for Sick Children, Toronto; George E. LaCroix, M.D., associate professor, Department of Gynecology and Obstetrics, Wayne State University School of Medicine; and John P. Harm, M.D., instructor in pediatrics, WSU School of Medicine.

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Breaking News
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Doctor Huebner, Doctor Zako Lead MSMS Volunteer Physician Lobbyists

R. J. Huebner, M.D., and Louis R. Zako, M.D., Detroit, are the first two MSMS members scheduled to spend a week in Lansing as volunteer lobbyists for MSMS. Doctor Huebner spent Jan. 19-23 at the Capitol and Doctor Zako will spend Feb. 9-13.

The Physician Representation Program was approved by the House of Delegates in their 1969 annual meeting, and calls for one physician, under the direction of the MSMS staff, to be scheduled for each week of the 26-week 1970 legislative session. Sixteen MSMS members have been signed for one week each, with the remainder to be scheduled later.

Additional articles on the Physician Representation Program will appear in later issues of *Michigan Medicine.*

MSU Requests Nearly $30 Million To Start Teaching Hospital

Michigan State University has made a plea to local health planning authorities for a $28.8 million federal grant to build a teaching hospital, university health center and university clinics. The university's proposal was made by William B. Weil, Jr., M.D., of the MSU College of Human Medicine, before a Jan. 12 meeting of the Capitol Area Comprehensive Health Planning Association.

The hospital, visualized as primarily a referral hospital, will have 469,000 square feet. It is planned for occupancy in September, 1974. By 1978 it is expected to serve 100 first year undergraduate students, 400 advanced students and 3,000 continuing education students.

The hospital and the Life Sciences II building, to be built with the funds requested by Doctor Weil at the Jan. 12 meeting, will join Life Sciences I, now under construction at MSU campus, in a medical center complex.

Seven Physicians On Committee Planning Maternal Welfare Meeting

A committee of seven MSMS members, led by Darrell E. Statzer, M.D., Detroit, chairman, is heading up plans for the ninth annual Michi-

The MSMS Committee on Maternal and Perinatal Health, meeting Jan. 8 for the first time in the new year, heard reports from Jack Stack, M.D., Alma, left, regarding state legislative hearings on abortion law; from Jack R. Postle, M.D., center, chairman of the MSMS Subcommittee on Perinatal Morbidity and Mortality; and Joseph R. Cipparone, M.D., Lansing, chairman of the MSMS Subcommittee on Placental Tissue. The three speakers here look over materials presented by Doctor Cipparone.

Doctor Statzer

gan Conference on Maternal and Perinatal Health, scheduled March 25-26 in Flint.

The conference will be co-sponsored by MSMS, the Clara Elizabeth Fund of Flint and The Michigan Society of Obstetricians and Gynecologists. The location will be the Pick Durant Hotel.

On the committee are Jack W. Thompson, M.D., Flint, chairman of the 1968 and 1969 conferences; C. Arch Brown, M.D., Flint; John W. Hallitt, M.D., Flint; John P. Harm, M.D., Detroit; William J. Ledger, M.D., Ann Arbor, and James E. Harryman, M.D., Muskegon, ex officio member and chairman of the MSMS Maternal Health Committee.

Topics of the Wednesday afternoon through Thursday morning meeting will be Fetal Malformations caused by Amniotic Rupture during Gestation, Delivery of Maternal and Child Health Care, The Nurse Practitioner Program, The Nurse-Midwife Program, The University Role in the Delivery of Health Care, the Maternal Tissue Registry Quiz, The Treatment of Respiratory Failure in the Respiratory Distress Syndrome of the Newborn, Fetal Distress, and Intensive Care of Mother and Child.

MSMS, Wayne County Medical Society Plan Medicine-Religion Meeting April 1

The Wayne County Medical Society and the MSMS Committee on Medicine and Religion will co-sponsor an afternoon and evening regional medicine and religion meeting April 1 at the Wayne County Medical Society headquarters.

The day's activities will begin with a workshop from 4 to 6 p.m. for the chairmen of Committees on Religion and Medicine in the 30 county medical societies in the region, who will be invited to bring their clergymen with them.

Following dinner, for Wayne County Medical Society members, other interested physicians and their clergymen, a program about grief will be presented. Moderator will be the Rev. Paul B. McCleave, secretary of the AMA Committee on Medicine and Religion, and speaker will be the Rev. Granger Westburg of Williamsburg, Ill., who taught for 13 years in the Schools of Theology and Medicine at the University of Chicago.

Plans call for the panel to be made up of the Rev. Dwight Large of Central Methodist Church, Detroit; Mgsr. Francis Canfield, Sacred Heart Cathedral, Detroit; Winslow N. Fox, M.D., Ann Arbor, chairman of the MSMS Committee on Medicine and Religion; Ralph Cooper, M.D., Detroit, vice chairman of the MSMS Council, and John Moses, M.D., MSMS scientific editor.

MSMS Auxiliary's Third Annual Legislative Day Feb. 24

The MSMS Woman's Auxiliary will stage its third annual Legislative Day Feb. 24 in Lansing. Auxiliary members will be briefed on the events taking place at the Capitol by M. A. Riley, MSMS legislative counsel. They will also tour the Capitol and meet with their own legislators. Headquarters will be the Capitol Park Motor Hotel, downtown Lansing.

Future Of Medical Practice Topic Of Wayne Medical Alumni Clinic Day

The Wayne State University Medical School Alumni Association plans a two-day clinical session and reunion for 1970, in place of the previous one-day program.

Dates for this year's Clinic Days will be Wednesday and Thursday, May 13-14, with the event to be staged at Cobo Hall, Detroit.

The morning session the 13th will cover the future of medical practice in the U.S., with speakers to discuss private solo practice, private group practice, prepaid group practice and local and federally-regulated clinics.

The afternoon program on the 13th will take up how medical care is to be financed, with speakers on private and public sources of financing.

On the 14th, the entire day will be devoted to a program on new developments in medicine.

ACP To Sponsor Five-Day PG Course

The American College of Physicians (ACP) will sponsor a five-day postgraduate course on gastroenterology Feb. 23-27 at the University of Michigan Medical Center.

The course, one of 25 the ACP will conduct throughout the United States and Canada during the 1969-70 academic year, is primarily intended for internists who have important teaching responsibilities to physicians in all stages of training.

Course director is H. Marvin Pollard, M.D., professor of internal medicine and head of the section of gastroenterology.

Doctor Lowrey Takes Position At University of California

George H. Lowrey, M.D., formerly of Ann Arbor and scientific editor of *Michigan Medicine* preceding the current scientific editor, John W. Moses, M.D., Detroit, has taken a new position as head of the Department of Postgraduate Medicine at the University of California at Davis. Doctor Lowrey joins a medical school faculty headed by C. J. Tupper, M.D., former Associate dean of the University of Michigan School of Medicine, and scientific editor of *Michigan Medicine* before Doctor Lowrey.

U-M Ophthalmology Department Receives Grant to Combat Blindness

Another $5,000 grant to combat blindness has been awarded to the University of Michigan's Ophthalmology Department by Research to Prevent Blindness, Inc., of New York. In the past 10 years, RPB has given the U-M department more than $50,000 for an unlimited range of eye research.

Kelley Orders New Requirements For Charitable Organizations' Spending

Attorney General Frank J. Kelley on January 2 ordered strict new accounting requirements for charitable organizations after disclosure that some spend up to 96 cents to provide only 4 cents in benefits.

Under the new standards, charitable organizations would be required to spend at least 70 per cent of their funds for the purposes designated in their charters. Mr. Kelley said new reporting and accounting methods are being prescribed to enable the State to keep close tabs on how much is collected and how it is spent.

Attorney General Kelley said the new regulations are the result of a survey of the financial operations of 70 Michigan charities which collected $309 million from 1966-68.

MHC Estimates Need For 2,000 More Physicians

East Lansing — The Michigan Health Council estimates that Michigan needs about 2,000 more physicians now, and then adds that "Michigan should be providing 35 to 50 percent more education for medical students than it is now."

Latest report from the Michigan Health Council MD Placement Service indicates a need for 1,400 more specialists and 600 more family doctors.

John A. Doherty, MHC executive secretary, contends that, "unless Michigan legislators make ample financial provisions for our medical schools to expand to their maximums, not only will our small-town hospitals and clinics be without doctors, but many of our larger community hospitals and clinics will find themselves without adequate medical staff to meet the needs of patients."

Three Out-of-State Physicians Scheduled for U-M Lectures

Among the important meetings scheduled at the University of Michigan during the next month is the presentation of the annual Johnson Lectures Feb. 20. This year's topic is African lymphoma and the sponsor is the U-M Cancer Research Institute.

The lectures will be delivered by three authorities on the disease: J. N. P. Davies, M.D., professor of pathology at Albany Medical College of Union University; James T. Grace, M.D., director of Roswell Park Memorial Institute in Buffalo, N.Y., and Joseph H. Burchenal, M.D., vice president of the Sloan-Kettering Institute for Cancer Research in New York.

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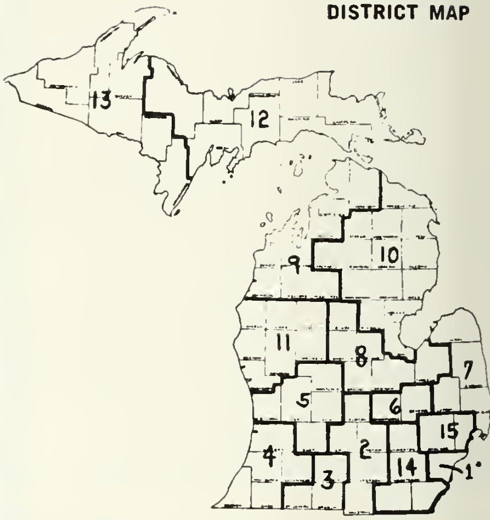

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Hubbard Opts Upjohn

William Hubbard, M.D., Dean of the University of Michigan Medical School and Director of the University Medical Center, is departing that university campus to accept a position with the Upjohn Company. This information, appearing first in a U of M news release, carried with it both a sense of surprise and a feeling of loss.

The State of Michigan and particularly its medical citizens are proud of the achievements of William Hubbard. Under his highly articulate and energetic direction, the U of M Medical School maintained its world-wide reputation for excellence in both teaching and research. In the process, Doctor Hubbard grew to greatness as an administrator. This was testified by his peers in the American Association of Medical Colleges who elected him their president in 1966-67. But greater proof is present in his record of accomplishment since he arrived on the Michigan campus in 1959 from New York University College of Medicine, where he had served as assistant dean and then associate dean.

In the Hubbard era at Michigan, the great advances in medicine and surgery were matched by triumphs in building new and improved teaching, research, and hospital facilities. Early in that decade came reports of medical breakthroughs. Progress continued apace through yesteryear with its successful surgical transplantation of the human heart. Concurrently, to a crowded medical campus was added a series of hospitals, the latest additions being a unique children's hospital, a giant new school for teaching the basic sciences, a superb postgraduate medical education facility, an advanced hearing institute, and a new drug-research resource — not to mention others of equal calibre.

During this time, Michigan led the nation in dollar volume of medically-oriented research projects.

To hazard a guess about the post-Hubbard decade, the 70's should witness great advances as the Detroit arrangement for increasing U of M medical teaching, research and service, flowers. This medical school cannot fail to maintain its leadership among the giants of medical education.

But whatever the advances of the 70's, William Hubbard will be in the midst of them, for he is still a young man who will continue to contribute to Medicine for many years to come — fortunately for Michigan, fortunately for the people of the world.

Robt. J. Mason, M.D.
MSMS President

county societies

Muskegon Society Hosts Columnist Ann Landers

At a recent Muskegon County Medical Society meeting, nationally-syndicated newspaper columnist Ann Landers held the spotlight. Her visit culminated two years of planning by county society members. She delivered a talk on "Teen-Age Use of Drugs and Narcotics" and was sponsored by the medical society in an appearance before an SRO audience of juniors and seniors in a morning assembly at Muskegon High School.

Joint Meetings Planned By Wayne Physicians

The Wayne County Medical Society held a recent joint meeting with medical staff members from Children's, Grace, Harper and Hutzel Hospitals, all of the Detroit Medical Center. Approximately 225 attended dinner and a talk on inner-city medical care by former Detroit physician Edward B. Cross, M.D., new Assistant Surgeon General of the U. S. Public Health Service and first Negro physician to attain this rank. A joint meeting with Wayne State University medical students is also planned for the society members by Program Committee Chairman Alexander H. Hirschfeld, M.D., Detroit.

Dual Topics Highlight Kent County Meeting

The "Present Status of Michigan Regional Medical Programs" and the "Drug Information Service through the Regional Medical Programs," were topics of discussion at the December meeting of the Kent County Medical Society. Speaker for the first was Albert E. Heustis, M.D., Lansing, director, Michigan Association for Regional Medical Programs, while Mr. Robert E. Pearson, project coordinator, Drug Information Center, the University of Michigan, delivered a talk on the second subject.

Southeast Michigan Doctors List Conditions Of AHOC Participation

Doctors in southeast Michigan have released a position paper detailing their interest and willingness to cooperate wtih local implementation of comprehensive areawide health planning, but listing conditions they believe must be met in respect to their participation.

Perhaps most significant of their recommendations is one "that 49 per cent of the permanent health planning committee be representatives from providers of service with the majority of these providers practicing physicians."

In the position paper, released Nov. 18, the southeast Michigan doctors stated that "before official support can be given to the plans of the Areawide Health Operating Committee on southeast Michigan, the physicians must have written confirmation that there will be an opportunity for the providers of service to participate actively in the program. Only in this way can the doctors be assured that the best interests of the patients will be fully protected and served and that the medical facilities and services are in accordance with medical standards and ethics."

Rubella Campaign Enlists St. Clair Doctors

Physicians in St. Clair County, as in all counties across the state, have been active in the Michigan Department of Public Health-sponsored immunization campaign against Rubella, or German measles. The St. Clair County Medical Society was one of four agencies, including the county health department, county chapter of the National Foundation March of Dimes and all participating schools, to sponsor the campaign in the county. The physicians were scheduled over a period of 20 days in St. Clair County to immunize school children between Kindergarten and third grade.

Automation in Office Oakland Meeting Topic

Members of the Oakland County Medical Society heard four experts discuss automation in the running of a medical office at their January meeting. Speakers were Mr. Melvin A. Lester, M.D., director of Check-Up, Inc.; Mr. E. Stevens Adams, president, and Mr. Deon J. Burns, Jr., of the Automated Management Systems of Detroit and Mr. Royce Carpenter, director of Merrill Medical Laboratories.

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IN THIS ISSUE

SCIENTIFIC ARTICLES

107 Surgery for Intra-Abdominal Lesions Associated with Resection of Aortic Aneurysms; William M. Stoll, M.D.
109 Recognition of Pulmonary Embolism; James K. Alexander, M.D.
111 Consent — a Problem in Medicine; Martin Lloyd Norton, M.D.
115 Neurilemoma of Bone: A Case Report and Review; Robert C. Dickenman, M.D., Guillermo Diazdel Castillo, M.D.
119 How to Start a Suicide Prevention Center Without Really Trying; Bruce L. Danto, M.D.
122 Non-Penetrating Duodenal Trauma; Coverage of Surface Defects of the Hand; Detroit Surgical Association
123 Group Therapy with Schizophrenic Patients; Armando R. Favazza, M.D.

SPECIAL ARTICLES

152 Gov. Milliken: Michigan Must Find Key to Public Action on Mental Health
174 The Council in Session: Three pages of candid photographs

OTHER FEATURES

93 breaking news
98 msms leadership
99 officers' page
100 county societies
104 your opinion please
107 scientific papers
118 monthly surveillance report
118 michigan authors
128 msms news
michigan mediscene
129 council minutes
132 welcome
137 about doctors
145 medical care programs
148 ancillary
162 medico-legal
168 editorial viewpoints
178 in memoriam
182 noted and quoted

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your opinion please

Do you believe quality of medical care is a professional responsibility and that government has no role in establishing standards or criteria to assess the quality of care provided to patients by physicians? Explain your opinion.

Richard A. Rasmussen, M.D.
Grand Rapids

Answer: Yes and No.

The quality of medical care is a responsibility of the medical profession because it requires knowledgeable professionals to evaluate it accurately. The profession must willingly assume this duty so as to deliver the best quality of care or service to the public or private consumer. The best quality requires good delivery. The profession must assume responsibility for requiring good quality care by all health agencies, facilities, including government or individual physicians. Wherever there is failure the profession should recognize same and make the needed appropriate correction. The physician must not default in this area. He is expected to provide leadership in this aspect of health care.

Organized medicine through the AMA Council on Medical Education in 1907 in Chicago recognized this principle when it established the grading of medical schools as A-B-C-D. Many schools of good quality and poor quality existed then. The result of this grading was that the poor quality school ceased because many states would not license their graduates. The medical college curriculum leading to the M.D. degree was thus designed to insure a high quality of physician so far as education is concerned. The AMA, the medical schools, other professional organizations such as the American College of Surgeons have continued to carefully select the qualified student for medical training and to observe him throughout this period. The physician is then required to maintain high quality through our hospitals, medical staff rules, medical organizations — county and state societies.

The government as a provider of the means for medical care for a large segment of our people (consumers) is and should be concerned about the "quality of medical care." It will also concern itself with the standards as criteria to assess "the quality of care" delivered by the physicians of our country. It is able to, and will employ physicians, to assist with this evaluation. It is hoped that these physicians will be well trained high quality physicians. They will necessarily consider and use the standards and criteria set up by our professional organizations: The AMA, ACS, Boards and others for evaluation of doctors, schools, hospitals, etc. The government should not and must not promote poor quality physician training or the resultant poor quality physician. The motto and policy should be that "even the best is none too good."

The best physician should be recognized as a person trained in the medical sciences to be an independent thinker who will ably apply his knowledge, who is often ingenious and resourceful in the control of illness and the development of new methods and techniques. This broad charge has resulted in great medical advances. It attracts and challenges capable students. It must not be dampened by unnecessary government controls.

The physician largely through organized medicine must recognize his responsibility for high quality medical care and be willing to require only the best in education, training, and the delivery of medical care. The government should, and will, insist upon no less. There should be no room for inferior quality care.

Frank B. Walker, II, M.D.
Grosse Pointe Park

While I definitely do believe that the quality of medical care is a professional responsibility, I realize that modern day practice requires the establishment of basic guidelines and standards to which all physicians must conform. However, the government also has a definite role in seeing that criteria are adopted which meet the standards necessary to insure that all federal and state regulations and legislative acts are adhered to. But its role should be confined to this aspect. Legislation of no kind can insure the desired goal of adequate good medical care for all without the full support and cooperation of the medical profession in drawing up its own basic standards and then enforcing them through its local peer review committees in individual hospitals, and county, state and national organizations. It is one thing for the government, at whatever level, to insure that all statutes are applied equally to all, but the regulations should first be established with the best possible professional medical advice and then kept sufficiently basic that the individual physician is free to practice in his own way as long as it conforms to these primary criteria. In the end, the ultimate responsibility belongs to the physician, and the physician-patient relationship should never be subjugated to the detriment of the patient.

John W. English, M.D.
Marquette

I believe that any modern government has a basic responsibility to insure the adequacy of health services rendered to the population it serves. Its role should include the views and recommendations of the responsible professions in the field, as well as those of other interested parties such as the consumer. The governmental commitment should not become a political weapon or tool but should be a public service function as independent of politics as possible.

The medical profession bears a great responsibility to recommend and strive for the best possible standards of medical care consistent with the available economic resources. It should be sufficiently active in this area to minimize the need for governmental involvement in the details of health care. It should be a major voice of counsel and influence in the structure of what governmental control is necessary. Nevertheless, the final responsibility for health services in our society is a governmental (i.e., society's own) responsibility. We have long since passed the point where a lassez-faire attitude regarding medical services is socially acceptable.

James F. Tobin, Jr., M.D.
Ishpeming

You who are concerned about the government "establishing standards or criteria to assess the quality of care provided to patients by physicians" are living in a dream world. It is against the nature of the beast called government (translate as bureaucracy) to provide money to anyone for anything without establishing standards and *control*. The name of the game is power and an avid lust for power burns in the heart of every bureaucrat from clerk-typist to cabinet head. And who better to exert power over than the superstitiously held wielders of power over life and death – the physicians.

We are asked to debate in print whether standards of medical care are better served by professional control or government control. Gentlemen, you are out of step with the times. The game is lost and we had better be ready for the next round. If you really thought that the issue at stake in the recently completed government coup was the quality of patient care you are lost in a fog. Governments don't care for quality – they feed on power and control.

Now as to the next round, this will be for the final conquest of absolute control of the physician himself. Where he shall work; in what field; for what salary; what patients he will be allowed to service; for how many hours a week; to what bureaucratic master he shall answer – these are the issues – not some highly held idealistic concept of bettering life and health. We have no recourse but to combat power with power. We physicians as a group have that power but we do not have the realistic, hardheaded leaders to render that power of use to us and to our patients.

There never has been any real question that the quality of patient care is best served by professionals holding the responsibility. By the same token there is no question that physicians acting independently as a free group in a free society serve the cause of health in a manner better than any in history. Nonetheless, if our leaders do not abandon their philosophical "above the battle" detachment and grapple with the hard realities of what power is really all about we (and our patients) shall lose the fruits of having the best system of health care delivery in all the world.

Is Medical Care A Right or a Privilege?

"Your Opinion Please" is a new monthly feature in *Michigan Medicine* designed to provide a forum for the views of Michigan physicians on vital issues. Your comments are invited in response to the question asked on this page.

A question is selected each month and interested physicians are urged to send in their reactions. Letters in response to the question for the April issue must be received in the MSMS office by March 1.

The April question will be:

"There has been considerable debate whether medical care for every individual is a right or a privilege. What are your views?"

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Report of 23 Cases:

Surgery for Intra-Abdominal Lesions Associated with Resection Of Aortic Aneurysms

BY WILLIAM M. STOLL, M.D.
GREEN BAY

The author has had the opportunity to perform additional surgery for other intra-abdominal lesions at the time of resection of abdominal aortic aneurysms. A total of 160 abdominal aortic aneurysms have been operated over a six year period. Twenty-three of these 160 have been operated for associated intra-abdominal lesions, without any deaths.

Surgical treatment of lesions of the abdominal aorta has brought about remarkable advances in the past decade. Aneurysms and occlusive diseases are the principal surgical lesions for which such operations are performed. Their incidence is steadily increasing as the life span of the population lengthens; and the risk of operations is increased by the advanced age of these patients.

THE PURPOSE of this report is to present an experience with resection of abdominal aortic aneurysms and to consider the risk and feasibility of performing associated operations during such aneurysm surgery.

There were no deaths in this series. The average age was 69 years. There were two complications. There was a wound dehiscence in one case, requiring secondary abdominal closure on the ninth post-operative day. Revision of a colostomy was required in one case of abdomino-perineal resection, due to decreased vascular supply to stoma.

Primary treatment consisted of resection of the aneurysm and its replacement by a Dacron vascular prosthesis. After this, the treatment of associated lesions was considered. The condition of the patient at this stage of the operation governs the practicability of secondary or tertiary procedures. The retroperitoneal space is first tightly closed to protect the vascular graft and the additional surgery is performed.

RESECTION OF AORTIC ANEURYSMS WITH ASSOCIATED SURGERY

NO. OF CASES	ASSOCIATED SURGERY
7	Cholecystectomy
5	Hiatal hernia
3	Vagotomy and pyloroplasty
1	Cholecystectomy and hiatal hernia
1	Incisional hernia
1	Abdominal-perineal resection
1	Cholecystectomy and abdomino-perineal resection
1	Cholecystectomy and repair of inguinal hernia
1	Gastrectomy
1	Nephrectomy and excision of tumor of ovary
1	Nephrectomy and cholecystectomy

PRE-OPERATIVE bowel preparation with sulfasuxidine was carried out in those cases of bowel resection. No special anesthetic or surgical measures were taken other than recording central venous pressure during surgery, and for three to four days post-operatively while in the intensive care unit. A woven Dacron prosthesis was used as a graft in all cases. The total operating time was from one hour to two and one-half hours. Penicillin and streptomycin were used post-operatively, with other antibiotics being used if indicated. The surgical intensive care unit was utilized from four to six days.

COMMENT

The assumption that the addition of secondary and tertiary procedures is hazardous after abdominal aortic aneurysmectomy is justified when one

scientific papers

The author is a Green Bay surgeon. William A. LeMire, M.D., Escanaba, MSMS Councilor from the 12th District, notes that Doctor Stoll is one of the most competent surgeons of whom he knows, and that many Upper Peninsula physicians refer patients to him.

considers the magnitude of the primary operation and the usual advanced age and generalized arteriosclerotic condition of the patient. These cases cited have, however, demonstrated that the performance of two or more different operative procedures concurrently need not increase the mortality rate or morbidity of the principal operation.

DeBakey et al[1] reported on 931 patients with aneurysm of the abdominal aorta. Of these, 69% had associated abdominal operations at the time of resection of the aneurysm. His series included 480 cases of appendectomy and 184 cases of sympathectomy. The author did not do incidental appendectomies and did not include the cases of sympathectomy in this report.

Probably the most feared complication of performing associated surgical procedures with resection and grafting for abdominal aortic aneurysms, is the possibility of graft complication or infection. DeBakey[2] reports a graft complication of 2% in over 1,700 cases of Dacron graft used as an arterial prosthesis. There were no graft complications in this series.

SUMMARY

One hundred sixty cases of abdominal aortic aneurysm have been operated by the author. Twenty-three cases having associated and symptomatic intra-abdominal lesions with aortic aneurysm, representing all of those encountered by the author, are presented. All but two of the cases had been hospitalized with symptoms pertaining to the associated lesions and not the aneurysm. The associated lesions were operated upon concurrently with resection and grafting of the abdominal aortic aneurysm. The average age was 69 years. There were no deaths and there were two complications: one wound dehiscence and one colostomy stoma which required revision.

THE FEASIBILITY of performing associated surgical procedures at the time of resection of an abdominal aortic aneurysm has been brought out in this report. The decision to perform associated procedures should be left to the discretion of the surgeon. A marked increase in operating time would probably be a contraindication to proceeding with secondary surgery. It appears important to determine the presence of a colonic carcinoma, which may be present, before carrying out aneurysm surgery. Other surgical procedures such as cholecystectomy, gastric surgery, etc., may be carried out without adequate pre-operative bowel preparation. One must be aware of the higher incidence of colonic carcinomas in this age group.

It is probably safer to perform secondary and tertiary procedures on an older patient than to subject such a patient to subsequent major surgery. One may consider staging the operations in a younger patient. The decision to perform the aneurysm surgery first, followed by subsequent bowel resection, should be established depending upon the specific case. A symptomatic and large aneurysm would have precedence over an asymptomatic carcinoma of the colon. Szilagyi et al[3] reported a case of unsuspected carcinoma of the stomach, discovered during surgery intended for resection of an abdominal aortic aneurysm. The gastric carcinoma was resected, but the aneurysm was not. The patient expired a few hours postoperatively from rupture of the aneurysm.

THE AUTHOR urges future reports regarding this subject, enabling vascular surgeons to evaluate further the performance of associated surgical procedures at the time of resection of an abdominal aortic aneurysm. The fear of graft infection has not proved valid, as illustrated in this report and that of DeBakey.[1]

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Recognition of Pulmonary Embolism

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The diagnosis of acute pulmonary thromboembolism may be derived from history, symptoms, physical findings, electrocardiogram, serum enzymes, chest roentgenogram, pulmonary function tests, isotope lung scan, and pulmonary angiography is by far the most accurate and specific in detecting the presence and extent of embolic disease. Indeed, angiography may be absolutely necessary to establish the diagnosis in the presence of congestive heart failure, or to differentiate such conditions as atelectasis, pneumonia, acute myocardial infarction, and peritonitis.

The symptoms of acute pulmonary embolism are notoriously protean, so that the disease may mimic a variety of neurological, cardiovascular, respiratory, and upper abdominal disorders. Dyspnea. restlessness, and apprehension are common, as are symptoms due to cerebral ischemia such as dizziness, syncope, and convulsive phenomena. Dull substernal pain signals massive embolism, and is probably secondary to coronary insufficiency. If pulmonary infarction ensues, pleuritic pain, cough, and hemoptysis may develop. Wheezing occurs infrequently with acute pulmonary embolism, though atelectasis and hypocapnia in the affected regions of the lung favor airway narrowing.

OF THE FINDINGS on examination, hyperpnea is the most consistent, and often the most striking. Though increased physiological dead space is a factor, the mechanism of hyperpnea in man is unknown. Oxygen administration usually produces little effect. Fever, tachycardia, and tachypnea are frequent findings. Signs of venous thrombosis in the legs develop in less than half the patients, and may not appear until days or weeks after onset of cardiorespiratory or neurological symptoms. Jaundice is more often due to hepatic dysfunction than to hemolytic mechanisms, occurring most frequently in association with congestive heart failure or chronic liver disease.

While certain symptoms and signs in an appropriate clinical setting may strongly suggest the diagnosis of pulmonary embolism, these same findings may obtain in other diseases. To establish the presence of acute pulmonary embolism, or to rule it out, additional diagnostic aids are almost always necessary. The conditions presenting differential diagnostic problems most frequently are pneumonia, atelectasis, pericarditis, cholecystitis, dissecting aortic aneurysm, cardiac tamponade, acute myocardial infarction, and hyperventilation syndrome.

APPRAISAL OF AIDS in diagnosis may begin with electrocardiography. In most cases, acute pulmonary embolism results in no definite electrocardiographic abnormality, and the transient nature of the changes, when they do occur, is characteristic. The electrocardiographic findings most commonly observed, namely sinus or supraventricular tachycardia, right axis deviation, right bundle branch block, and inverted T waves in leads V_1 to V_3 or V_4 may be helpful, but are all non-specific.

Elevated serum lactic dehydrogenase (LDH) along with normal serum glutamic oxalacetic transaminase (SGOT) and normal or elevated serum bilirubin favor the diagnosis of pulmonary embolism. However, LDH levels may not rise following embolism, and elevation is a non-specific finding, occurring also with cardiac failure, shock, pregnancy, liver disease, and after surgical procedures. In addition, LDH assay does not differentiate pulmonary infarction from pneumonia.

Chest roentgenographic findings may be suggestive of embolism, but are not often diagnostic. Before frank infarction develops, the chest film may show no abnormality. In some cases, enlargement of main pulmonary arteries or their major branches is discernible, with absent or diminished pulmonary vascular markings peripherally. The hemidiaphragm on the affected side may be elevated, due to atelectatic changes. Pulmonary densities appearing after infarction are typically subpleural, may be transient, are often associated with effusion, and most frequently involve the right lower lobe.

Scintillation scanning of the lungs, after intravenous injection of macro-aggregated human serum albumin particles labeled with I^{131} or other appropriate radioactive material, is a useful technique in the diagnosis of acute pulmonary em-

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bolic disease. Since most of these particles have a larger cross-sectional area than the average pulmonary capillary, they are trapped at precapillary level during the initial transit through the lungs, and the distribution of radioactivity reflects regional pulmonary blood flow. Thus, segments to which the blood supply has been interrupted by occlusive thromboemboli will appear as "cold areas" or areas of diminished radioactivity on the lung scan. This method is advantageous because it is virtually without risk, and lends itself well to the performance of serial observations. However, any condition leading to reduced or absent regional capillary perfusion may produce alterations in the lung scan so that reduced radioactivity over the site of a pulmonary infiltrative lesion on the chest film can be anticipated regularly, and provides no differential diagnostic information.

THE DIAGNOSTIC POTENTIAL of the scanning procedure is greatest when embolism is suspected, but there is little or no abnormality found on the chest film. Even under these conditions, "cold areas" may be found, particularly over lung bullae, in obstructive lung disease, or over the lower lobes with left ventricular failure. Conversely, in some cases little abnormality in the scan may be seen where thromboemboli produce partial but not completely occlusive lesions. Though cautious interpretation is required, the lung scan remains a very useful screening procedure in the diagnosis of acute pulmonary embolism, and once the diagnosis is established, may provide information regarding the course of the disease and response to therapy.

Visualization of the pulmonary vasculature can be accomplished by either selective or venous angiography. In patients with acute pulmonary thromboembolism, the chief angiographic findings are complete or incomplete obstructions of various pulmonary arterial branches, intra-arterial filling defects, decrease in volume of affected lung segments, and changes in arterial caliber proximal or distal to the obstructive lesions. In other cardiorespiratory diseases such as cardiac failure, pneumonia, pulmonary tumor, abscess, bulla, fibrosis or emphysema, the pulmonary arteries may be compressed, displaced, or attenuated, but remain patent to the subsegmental level, showing neither filling defects nor obstructive lesions.

Thus it is the identification of specific structural changes within the pulmonary arteries that renders angiography the most definitive diagnostic method available. The decision to perform arteriogrophy ultimately must be a matter of clinical judgment, based on the status of the patient, facilities available, and possible therapeutic implications. Angiographic demonstration of pulmonary thromboembolism would appear essential before pulmonary embolectomy, and highly desirable before interruption of blood flow through the inferior vena cava.

Consent - A Problem in Medicine

BY MARTIN LLOYD NORTON, M.D.
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It is the purpose of this paper to delineate the various aspects of obtaining operative and therapeutic consent as applied to the practice of elective medicine. I will indicate that, at best, this consent is only an indication of an attempt to inform the patient of the proposed procedure and the alternatives thereto, with the risks involved. I will also demonstrate that, at its worst, this consent may be a self-serving document, obtained under circumstances of implied coercion. Finally, I shall propose one approach to the correction of this problem. I will further suggest other avenues leading to control of the overall and basic question at issue — that of the growing tide of medical malpractice litigation.

A physician has a duty to inform his patient fully of the dangers inherent in any proposed treatment or surgery. Unless he does, the patient's consent to the treatment will not be effective to bar recovery in an action against the doctor for battery, since, had he been informed the patient may have declined the treatment. Indeed, he may be prosecuted criminally and/or be held civilly liable.[1] — This statement may be found in many texts dealing with the topic of Medical Malpractice.[2] One notes that the specific tort involved is that of battery.

THE AVERAGE PHYSICIAN, naive in the concepts of Law, thinks of the transgression under the general term of "malpractice." To the technically enlightened, this is a misnomer since malpractice is too inclusive a term and, indeed, really involves the concept of negligence, an unintentional tort. However, an attack upon one's person (assault and battery) falls within the category of intentional torts, to which the privilege of "consent" is available *with qualification*. However, from confusion about the technicalities of this concept, admixed with the physician's fear of "legal action", compounded by the patient's propensity for redress of real or imagined wrongs, as well as ever increasing professional liability insurance rates, there has arisen a reliance upon "operative and therapeutic consent procedures". The phrase *volenti non fit injuria*[3], serving as a basis for these procedures to eliminate the chance of liability, really indicates the concept in negligence law that consent would imply NO cause of action as a matter of law.

What is "consent"? What does it imply? Where does it originate? Justice Cardozo stated[4] "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."[5] Thus "consent" is an indication, either oral or written[6] that the patient understands what is to be done and the risks involved[7, 8].

Who many effect "consent"? Any adult of sound mind may agree to the procedure as regards himself. The phrase "sound mind" necessarily involves the ability to understand alternatives and implications as well as the specifics of the therapeutic means to be effected. As for a minor, consent of a parent or guardian is required except in emergencies. Their authority[9] is based on the responsibility to raise the child to adulthood[10]. However, one who is below legal age of consent, but either is married and/or living apart from parental support and control would be considered an "emancipated minor" and entitled to grant permission as if he were of adult age. Thus the 18 year old married mechanic would fall in this category, as would the 18 year old secretary who lives apart from her family supporting herself from her occupational earnings.

However, this ability to consent has been even more broadly interpreted in at least one significant opinion to include any person with "sufficient capacity to understand the significance" of his or her acts[11]. Similarly treated is the situation of the mentally incompetent (next-of-kin serving as the guardian)[12], although this is not complete since one may be considered capable of making a value judgement in one situation and not so endowed in other situations[13].

The next point at issue is the form of the consent obtained. We have already indicated above that it may be oral or written.

A further distinction is that of express versus implied consent. "Express" signifies a formal acceptance of the proposed operation. "Implied" signifies acceptance by action, e.g., a person who holds up his arm to be vaccinated[14]. This

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pre-supposes that the patient (a) knows that he can either agree or refuse, (b) knows or has been fully and fairly informed as to what is to be done, and then (c) cooperates with the physician without duress[15]. Oral consent is ordinarily supplemented and reinforced by implied consent.

The scope of consent inherently involves necessary limitations. It must be an "informed" consent, which implies that the specifics of the procedure planned are explained, including the risks, alternatives, and inherent implications. However, the explanation may be limited if such details would adversely affect the pathophysiologic status of the patient[16]. Obviously, procedures that are specifically forbidden are absolutely limited, as would be extension of the operation beyond the area of elective surgery.[17] The physician often conceives of the consent being a rather general authorization.[18] However, this is a loose interpretation not supported by the "facts-of-life" of medical practice. If, in the course of surgery, a surgeon finds another condition which materially or substantially endangers the life, limb, or health of the patient, he would be justified in extending the procedure.[19] The definition of "materially or substantially endangers" is left to the jury to judge, based on expert witness testimony.

WHAT IS WRONG here? A view of the situation in practice reveals on one hand a sincere concerted effort to inform the patient about his condition and the therapeutic problems, remedies and alternatives. Some patients (in the author's experience a pitiful few) truly understand, and less have the ability to evaluate the alternatives. On the other hand we see operative consent forms blindly being demanded of patients with the coercive alternative of refusal of admission to hospitals or needed therapy. The choice is — sign, or we will not help you. Is this really an informed consent, an implied consent, or one based on fear and duress? As one of my patients stated "What can I do? If I don't sign the consent form and I go to another physician, he will likewise demand the same."

THE SAME REASONING applies to hospital services as for physicians. Any advocate "worth-his-salt" can demonstrate that his client did not fully understand the nature and risks of the procedure, and therefore that there was *no* informed consent. He can also demonstrate a mode of implied and explicit compulsion (sign or we will not operate, or admit you to the hospital) — then there is no *voluntary* consent. (Obviously, this review does not include herein a discussion of emergency life-saving situations, where these comments do not apply.)

While all aspects of our society are involved in this problem, the social strata particularly affected by this dilemma is that very group most in need of protection, namely the economically and educationally destitute. The situation is even more acute in this group of patients than in the so-called typical patient.

WHAT HAS BROUGHT us to this state of circumstances? The answers are multiple, and not necessarily in the order of historical development or importance. The propensity of the population to institute legal action for real or imagined wrongs[20] urged on by some of our legal colleagues enthused by the conceptual trend to "reach into the deepest pocket" wherein "all risks of man in modern society must be recompensed-for," and the platitude that "professional liability insurance will take care of it" has been painfully obvious[21]. The effect, where the physician is concerned, has already resulted in the forecast of the California District Court of Appeals (supra) that it would "subject the medical profession to an endless possibility of harassment and place upon them a potential of punishment where their examination or treatment results in less than complete success."

The general consensus[22, 23] is that both the volume of claims and the amounts of awards have moved sharply upward in the last few years. This is reflected in the continuing increases in malpractice insurance premiums, the tightening of underwriting standards and the withdrawal of some major companies from some geographic areas or from the malpractice field as a whole. Despite constantly improving standards of medical care the medical profession is faced with the anomalous situation of a deteriorating liability experience. Thus, we have the fear of the physician of anything "legal." This fear has been increased a thousand fold as he hears of judgements in excess of $1 million[24]. Indeed, in many cases, this fear and the resulting "cautious" actions of some physicians is unreasonable, in view of the sparsity of these decisions supported on the Appeals Court level.

A FURTHER ASPECT of this problem is lack of understanding. The attorney is not cognizant of the mechanics of diagnosis and therapy, patient-doctor interrelationships, and the vagaries of medical practice. He appears, as the total advocate, to be concerned only about "winning," not "right" or "wrong." The financial rewards of success are apparently supercedent to the long-term effect on medicine and its relation to social needs. Certainly this is a very great part of the currently evidenced schism between the physician and society, and more especially between the attorney and the physician.

The physician and the public likewise are guilty of misunderstanding, at the least. They look upon each and every legal approach as a reproach of the most reprehensible nature. Malpractice actions are considered by the physician and the layman as social punishment for failure of the sincere desire of the physician to help his patient. It is an anathema for the physician bred through 12-16 years of training in Hippocratic Principles. This is surely, in part, a result of a lack of understanding about "negligence" actions, and the differentiation between intentional and unintentional torts.

The Intentional Tort is one that involves an act by the defendant, with the desire to produce a specific effect upon the plaintiff, and which has indeed been the causation of such effect.

The Unintentional Tort includes that grouping wherein the issue of negligence is of prime import. Herein, there is a responsibility of the defendant towards the plaintiff. This followed by an act or omission to act on the part of the defendant. Such act or omission must then represent a breach of duty (responsibility). This must, in a sequential manner, be a cause of injury to the plaintiff, if not as an actual causal element then as a proximate cause in that it has set in motion a sequence of events that eventually did incur injury to the plaintiff. Note that here, the motivation or desire of the defendant is not involved: And herein lies the bone of contention. In the doctor-patient relationship the concept of "intent" as related to the Intentional Tort and the concept of the Unintentional Tort legally distinguished, may be and should be considered as no more than a legal fiction.

There must be a broadening of this concept similar to that of "assumption of risk" when discussed in relation to assault and battery cases in the intentional tort category. We must recognize that the physician is "human", that science is fallible, that just by living in an increasingly complex society we must, as patients, likewise accept some of the risks of that society. While we certainly have no desire to protect the charlatan, the quack, the incompetent — we must likewise not destroy the relationship between the physician and that very society of which we speak. These are only a few of the culprits. Suffice it to say that the original purposes of legal protection have expanded from the Common Law tort of Trespass to Person, to the Pandora's Box of Assault and Battery as currently applied to the physician in practice.

WHAT OTHER APPROACHES can be taken to counteract the enigma? As with any oversimplification, there is no ONE. Despite some unenlightened decisions[25] making it virtually impossible for a physician to obtain meaningful relief from action other than wilful, wanton or gross negligence, there *must* be some means to contain the mushrooming number of lawsuits and excessive judgements.

A start in this direction has been the interprofessional (Law and Medicine) Review Boards for cases to be subjected to legal action in the "malpractice" field. A fine example is that operating under the New Jersey Supreme Court Rule 4:25B, effective since February 1966 which adopted and established a panel structure "with the view to (a) discouraging baseless professional liability cases and (b) making expert medical testimony available to claimants in those professional liability cases where there is a reasonable basis for the claim." To quote from the provisions of this plan[26] —

> "Provision is made for claimant to initiate proceedings to be heard by a subpanel of two doctors, two attorneys, and a former judge. The doctor against whom claim is made must consent to the hearing. Testimony may be sworn or unsworn and cross-examination is allowed. The subpanel hearing is coordinated with the investigation of the insurance carrier.
>
> "If the subpanel determines that there is no reasonable basis for the claim, the claimant is advised that action should not be instituted. If the claimant's attorney agrees in advance not to pursue legal proceedings if the subpanel determines there is no reasonable basis for the claim, and thereafter the subpanel decides a reasonable basis exists, the claimant will be supplied with the names of three medical witnesses to serve at a reasonable fee to be paid by the claimant. If the subpanel determines there is no reasonable basis for the claim, the claimant's attorney is precluded from thereafter appearing for the claimant in any legal proceedings, although it is expressly provided that this does not prevent the claimant from obtaining other counsel. All proceedings are confidential and may not be disclosed in later proceedings without the consent of all parties."

Operative, therapeutic and diagnostic consent must be more than an imposed acceptance.

As in all society, it is the extremes that place a burden on man. However, the patient and his family must accept the fact that — with all good intent — man's knowledge and skill is not infallible. Motivation and purpose should indeed be a legal factor in malpractice actions. Intent, in the sense of the desire to accomplish a specific objective rather than what is generally considered as "legal intent" must also become a basis as a defense in such cases. This concept must, and should carry a special connotation in medical situations particularly as it applies to "Consent." This would be akin to a consideration of "wilful and wanton disregard" terminology as used in other situations.[27]

We hold the physician to a higher standard of care than other professions. What is technically a battery should not be considered a medical battery. There *is* a special relationship established between patient and physician and it is time that the courts recognized that this relationship is a two-way street — involving the acceptance of risk and responsibility by the patient as well as his voluntarily chosen physician.

WE MUST APPROACH the problem from many aspects, and with a view to long-term results. We must institute an interprofessional educational program such that the legal and medical professions truly become brother-professionals. Such programs on medical jurisprudence should be conducted by the Schools of Law and Medicine, as joint ventures, with instructors from both faculties simultaneously directing the instruction. These courses should have students from each of the Schools teamed up so that each may give to his brother-professional of his knowledge, and receive reciprocally. We must, as co-students, expose ourselves to the concepts, the problems, the objectives and tools of our respective fields.

Lastly, we must submit to jurisprudential consideration proposals indicating technical changes that can be considered to change the climate that now exists, namely that of attorney and physician being adversaries and antagonists. The changes in forms of defense suggested herein are only an indication of what might be done, what can be done, what should be done, in regard to one aspect of the growing cancer of malpractice-type actions. The suggested approaches to its control are not new — but they do require education and discipline to develop. Much has been written on both sides of this problem. It is time for action.

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A case of primary neurilemoma of bone involving the ulna of a 32-year-old male is reported. The lesion was removed and uneventful recovery occurred. A review of the literature was done with 38 reported cases being discovered. The lesions were benign with no unusual sex distribution and occurred most commonly in the fourth and fifth decades of life, the mandible being the most common site. Pathologic fractures are rare in these lesions.

Neurilemoma of Bone: A Case Report and Review

BY ROBERT C. DICKENMAN, M.D.
GUILLERMO DIAZDEL CASTILLO, M.D.
DETROIT

Primary neurilemoma of bone is a rare neoplasm. The nerve supply to bone, both autonomic and peripheral, is derived from the richly innervated periosteum and minute trunks accompanying the nutrient vessels. From the periosteum minute nerve fibers enter through the Volkmann's canals giving ramifications and anastomoses with no definite nerve endings. The nerves accompanying blood vessels are largely of autonomic origin and are small ramifying plexuses.[1] Neurilemomas which rarely arise from these may produce rarefaction of bone, or may be located in the nutrient canal with production of dumbbell-shaped tumors.[2]

REPORT OF A CASE

A 32-year-old, Negro male was seen for the first time in the Emergency Room with a painful, swollen left elbow immediately following injury at work. The patient had accidentally fallen, landing on his left elbow. There was local edema and tenderness. Radiological examination showed a pathologic fracture of the proximal ulna (**Figure No. 1**) with a local area of abnormal bone suggesting a primary bone tumor. A benign endochondroma, or tumor with extensive chondromatous element, was suspected. At surgery the area was a cavity with a tumor mass that was entirely enucleated and delivered intact with capsule. Bone grafts from the iliac crest were placed in the cavity and routine closure done.

The tumor mass was 9 x 4 x 3 cm and had a thin, well defined, smooth capsule. (**Figure No. 2**) On section the tumor was soft, yellow-pink and had areas of cystic degeneration and focal areas of old and recent hemorrhage. Microscopically, the tumor consisted of a typical encapsulated neurilemoma with palisading Antoni Type A areas and other predominantly Antoni Type B areas with occasional Verocay body formation. Cystic, hemorrhagic and degenerative changes were present. (**Figure No. 3, 4**) No unusual cellular activity was noted.

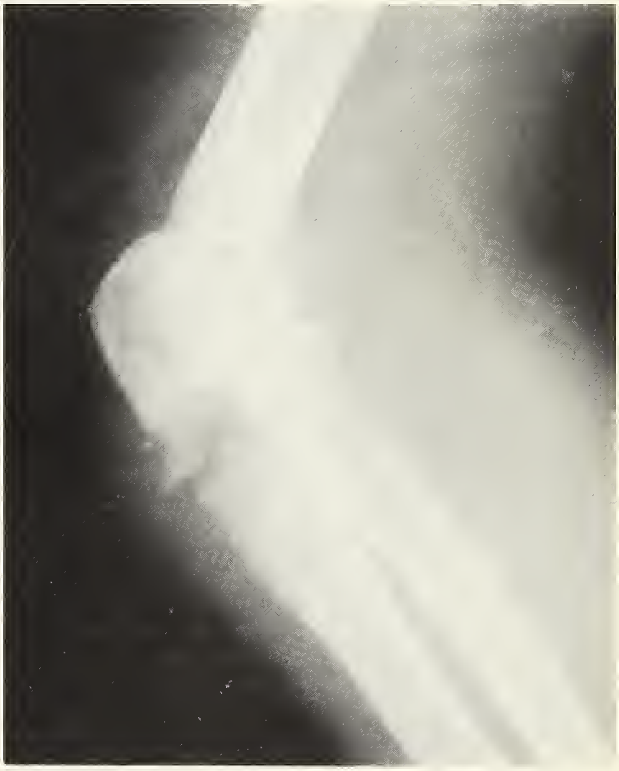

Fig. 1

The patient had an uneventful recovery with rapid functional recovery of the arm.

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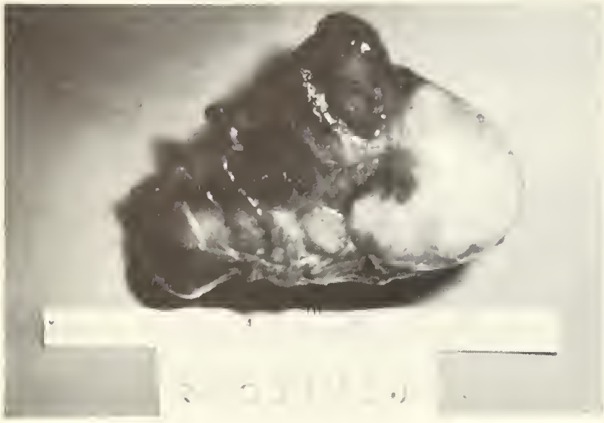

Fig. 2

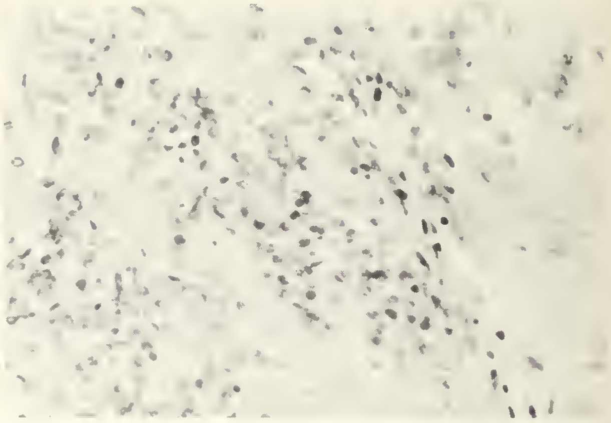

Fig. 3

COMMENT

Neurilemomas were histologically described by Verocay in 1908 and elaborated by others including Stout in 1935, who presented fifty-two cases. None of the cases had developed in bone. Our review of 38 reported cases of primary neurilemoma of bone reveals no sex predominance. The age range is from two and one-half years to 65 years with lesions occurring more predominantly in the fourth and fifth decades of life.[3] The mandible is by far the predominant site for occurrence[2,4,5,8,9,10,13,16,17] probably because of the rich mandibular nerve supply. Four tumors have been reported in the sacrum;[2,15,21,22] three in the humerus;[2,14,20] three in the ulna – including the present case;[1,2,3] two in the femur;[3,6] two in the maxilla;[24,25] two in the phalanges;[11,18] two in the metacarpals;[1,9] and one each in the fibula,[15] patella,[14] scapula,[3] and rib.[12] The most common symptom is pain, sometimes associated with local manifestations, predominantly edema. Pathologic fracture, although not common, may occur[1-6] when the lesion presents in a long bone. Two of the three reported pathologic fractures have occurred in the ulna. Although commonly considered a benign lesion,[1,2,3,11] recently a malignant transformation of a supposedly benign encapsulated neurilemoma has been described by Carstens and Schorodt.[7] The latter authors described a 93-year-old woman with a neurilemoma of the thumb with typical benign Antoni Type A and B areas as well as malignant areas resembling neurofibrosarcoma.

Radiologic examinations of the lesions usually suggest bone cysts, cystic lesions or chondromatous lesions.

Local excision and bone graft if necessary is the recommended therapy, since recurrences, although reported[2,3] are rare.

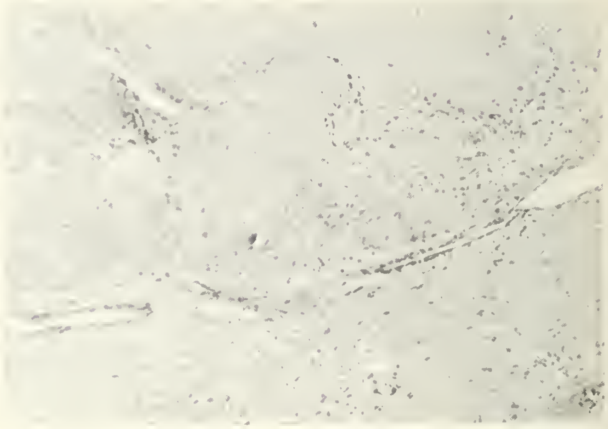

Fig. 4

SUMMARY

A case of primary neurilemoma of the ulna was presented together with a review of other reported cases emphasizing the rare occurrence of the tumor and the basically benign nature of behavior.

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Monthly Surveillance Report
Cases of Certain Diseases Reported To The Michigan Department of Public Health For the Five-Week Period Ending January 2, 1970

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1969 THIS 5-WEEK PERIOD	1968 SAME 5-WEEK PERIOD	1969 TOTAL TO ABOVE DATE	1968 TOTAL SAME DATE	TOTAL CASES FOR 1968
Rubella	215	173	4307	1953	1953
Measles	46	39	401	352	352
Whooping Cough	24	24	192	429	429
Diphtheria	—	—	—	—	—
Mumps	517	626	5215	14655	14655
Scarlet Fever & Strep Sore Throat	1379	1131	9763	10101	10101
Tetanus	—	2	5	5	5
Poliomyelitis (Paralytic)	—	—	—	3	3
Hepatitis	344	285	3361	2356	2356
Salmonellosis (Other than S. typhi)	40	48	539	614	614
Typhoid Fever (S. typhi)	—	1	6	1	1
Shigellosis	15	65	300	346	346
Aseptic Meningitis	12	18	181	265	265
Encephaltis	6	19	119	114	114
Meningococcic Meningitis	12	10	115	94	94
H. Influenzal Meningitis	5	7	55	64	64
Tuberculosis	165	164	2108	2664	2647
Syphilis	242	313	4021	5332	5351
Gonorrhea	1584	1445	19194	18213	18153

Information can be supplied by the local health department on the local incidence of disease.

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How to Start A Suicide Prevention Center Without Really Trying

BY BRUCE L. DANTO, M.D.
DETROIT

INTRODUCTION

You can't!

Despite the fact that Detroit is the fifth largest city in the United States and Michigan one of the largest states in this country, neither could lay claim to the establishment of a Suicide Prevention Center until late in 1968. California alone has 27 of the country's total of 140.

Detroit gave rise to two pioneers in the field of suicidology, Thomas A. Petty, M.D., and Viggo W. Jensen, M.D. In 1958, based on a study of several hundred successful and attempted suicides over the preceding few years, they published one of the most significant papers in the history of suicidological bibliography,[1] one which laid the foundation for establishing the clinical conceptual foundation of such a center. In light of their work, it seems incredible that it wasn't until 10 years later that a center for suicide prevention was established in the community in which their study was conducted.

Important among the factors which motivated the author to begin work on the establishment of such a center were the facts that the above authors were his teachers during his residency and that his residency training was located at Detroit General Hospital where a large share of total suicide attempts are screened and treated in terms of emergency room care.

DEVELOPMENT OF THE SUICIDE PREVENTION CENTER

In December, 1967, the initial step toward establishing the center was undertaken. Since no articles on how to establish one were available or had been written, a decision to meet with other involved agencies was chosen.

A MEETING was arranged with representatives of local mental health programs, both in-patient as well as out-patient; Planned Parenthood; various religious organizations; officials from the Department of Health; the police department including the women's divisions; United Foundation; family service agencies; social welfare divisions; the city-county community mental health agency; the Al-Mar Telephone Answering Service; the Michigan Bell Telephone Company; various public and private hospitals; the Michigan Employment Security Commission; the Division of Vocational Rehabilitation, and staff members of the Detroit Psychiatric Institute. Endorsement, without commitment for funding, as well as suggestions were made.

Subsequently, the author made a trip to California to meet with staff members of the Los Angeles Suicide Prevention Center. Many rich ideas came from the contact with people connected with the latter program. They were gracious enough to give the author copies of papers they had written on suicide, recruitment and training of volunteers, budgetary needs, client or patient call report forms, ideas for research and, above all, psychological support for undertaking the project.

Following his return, the author dictated over 700 individually-written letters to various corporations, foundations, businesses and prominent citizens. To everyone's surprise and disappointment, not one request was answered by a commitment to help or was accompanied by a check. All parties, however, were enthusiastic about their endorsement and many followed their replies with anxious cries for help regarding some of their employees who were depressed and threatening or attempting suicide.

VITAL TO the effort to enlist cooperation and interest in the program was the request and achievement of endorsement from the local county medical society and Michigan Society of Psychiatry and Neurology. Many people in the news and communications media required such endorsement before they were able to publicize the program.

Following the initial phase of publicity released through local newspapers, radio and television stations, a president of a medical fraternity auxiliary offered her assistance. She organized an art

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show which was held in May, 1968, at the community auditorium of a large retail store. Over $1,000.00 was obtained from the show; both as a result of the art which was sold, a percentage of which the dealer turned over to the center, and from donation canisters which were set up near the door for those who wanted to contribute but not buy any art.

Slowly, small contributions began to swell the bank account of the Suicide Prevention Center. It had been estimated by the answering service and telephone company that $3,500.00 would be needed to cover the annual cost of installing the telephone equipment as well as for the telephone and answering services. When this figure was near at hand, another publicity campaign was launched to recruit volunteers. Approximately 60 volunteers were secured to provide telephone coverage on a 24-hour basis. Two volunteers were selected to cover each of four shifts during the day, the first two of which were to be held at the hospital center and the remaining two to operate from their homes after 4 p.m. when the answering service would pick up the calls.

THE VOLUNTEERS' ORIENTATION PROGRAM

The movie, "A Cry for Help," was purchased from the National Institute for Mental Health. Another film from Roche Laboratories describing how the physician can learn to recognize the potential suicidal patient was borrowed and also presented. The orientation meetings were held two mornings per week for the daytime volunteers and on Sunday mornings for the nighttime people who were holding jobs during the week days. The Sunday meetings were held at the author's home. Of great assistance at the meetings was the Mental Health Public Health Nurse Consultant who has served as assistant director of the program.

SOME STAFF members at Detroit Psychiatric Clinic made themselves available to give lectures on growth and development, psychotherapy and community social welfare, health and safety agencies which could be utilized as resources for referral of suicide callers. The author presented formal lectures and conducted group discussions on the primary target area, suicide, in terms of its psychodynamic, social and medical aspects. Additionally, he discussed several tape recordings of calls handled by volunteers borrowed from a California suicide prevention center. Although many of the rescue situations on the tapes were poor technique and reflected a poor level of understanding on the part of the pastoral volunteers, they provided a basis for discussion and for pointing out features missed by the taped volunteers. Several meetings were designed to handle discussions of various kinds of problems connected with suicidal ideation and behavior and how to deal with them.

At the beginning of the training period, Dr. Edwin Shneidman accepted an invitation to participate on a panel to discuss a case of successful suicide occurring by way of an escape from the in-patient unit. He was most helpful in generating interest on the part of other staff not connected with the center.

As the orientation program neared the end of its five-week period and the financial needs for the first 12 months of operation materialized, the opening was set for November 8, 1968. However, one week prior to the opening a premature news release arising from the Department of Health brought an onslaught of calls from potential suicidal citizens. The author and his nurse assistant handled all the calls, as they had been doing on a smaller scale since the initial publicity in January, 1968, and became alarmed over the fact that the answering service wasn't in operation to transfer the calls to them over the week-end. Despite the disjointed and accidental beginning, callers and various organizations were patient and understanding about the unanswered telephones at night and over the week-end.

Once officially opened, after the trumpets of press, television and radio had ended their flurries of sound, the initial burst of 200 calls over the week-end began to settle down to what has proven to be a similar figure per month.

Space and the scope of this paper do not permit a detailed analysis of the calls. Perhaps a follow-up paper will allow for a closer look at figures and facts about the callers. However, some observations can be made here. First, many calls come from not only the tri-county area (Wayne, Oakland and Macomb) but also from distant cities and communities like Flint and small ones in nearby Canada, Ohio and Illinois. Second, a significant number of calls involved threatened homicide as well as other forms of crisis situations requiring intervention.

AFTER THREE months of operation, over 50 volunteers had acquired satisfaction and professional combat experience at handling suicide and other crisis situations. Countless hundreds of people were able to hear their cry for help answered at all hours of the day, their calls were followed up to insure effective rescue, numerous community groups were educated about suicide prevention, a few other communities developed interest in establishing similar centers themselves, seminars were established at local police departments, the Detroit-Wayne County Community Mental Health Services Board agreed to recommend funding of a proposed budget of approximately $40,000.00 to add additional staff and equipment for the center and two graduate social work students selected the first two groups of callers for two groups whom they will treat by group therapy.

Community health, safety and welfare agencies as well as the telephone company and answering service have integrated their resources with that of the center. Their collective telephone lines continue to hum with the cries for help and threatened notes of despair. But now, those cries are heard, dealt with and salved, and humanity has been expressed by the answer at the other end of the line: "Hello, Suicide Prevention Center, may I help you?"

ADDENDUM

One of the volunteers suggested that an auxiliary be started so that other lay members of the community who were not interested or capable of serving as volunteers to man the telephones could be involved with the Suicide Prevention Center.

Formulated was a type of auxiliary entitled Suicide Prevention, Inc. which is designed to be run by a lay board of its members with the director of the Suicide Prevention Center serving only in a consulting capacity. Current thinking among the membership is to use funds that will be raised through various efforts for purposes of making a movie for educational purposes about suicide prevention since none exists about a suicide prevention center itself. Monies could also be used to make available scholarships for psychiatric and para-psychiatric personnel to study as well as do research in the etiology of and the programing approach to the problem of suicide and its prevention. Of interest also is the prospect of establishing a community chair on suicide so that outstanding national speakers can come to the community to participate in special annual programs on suicide for purposes of community wide education on the problem. It is felt that this organization will offer the community an opportunity to voice its concerns, interests in and suggestions for suicide prevention so that it will be a community mental health program in the broad sense of the word rather than a medical or government bureaucratic establishment.

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The following are abstracts of papers presented at the September meeting of the Detroit Surgical Association.

Non-Penetrating Duodenal Trauma

BY WILLIAM G. KIBLINGER, M.D.
KIM K. LIE, M.D., F.A.C.S.
JOSEPH L. POSCH, M.D., F.A.C.S.
ALL OF DETROIT

In treating common injuries of the hand, it is frequently necessary to provide skin coverage for surface defects. The paper describes the several advantages and disadvantages of several types of grafts. A few requirements of donor skin have been described and the history of development of providing durable skin grafts to the volar surface of the hand and fingers are described.

A new method of providing ideal skin coverage has been described by using the hypothenar area of the palm as free full thickness palmar grafts for coverage of surface defects. Initially, this method was used to replace unsightly, previously applied skin grafts, but we have extended the use of this method for primary skin coverage in acute injury with excellent results. Details of the technique, the advantages of this method and indications are described. The results of skin grafts which were applied to twenty patients are described.

FREE PALMAR SKIN GRAFTS FOR

Coverage of Surface Defects Of the Hand

BY EDGAR ROMAN, M.D.
YVAN SILVA, M.D.
CHARLES LUCAS, M.D.
ALL OF DETROIT

The treatment of blunt duodenal trauma has improved since the beginning of the century when there was an approximate 90% mortality rate. However, this injury still carries a 25% mortality in most series.

Twenty-two cases of blunt duodenal injuries have been treated by the Wayne State University Department of Surgery over the past ten years. Seventeen of these injuries occurred in automobile accidents and the steering wheel was specifically mentioned in most instances. In addition, many of our patients had been drinking.

Two patients with isolated duodenal hemotomas were successfully treated by evacuation and drainage. Six out of seven patients with duodenal perforation in the absence of pancreatic injury were successfully treated by simple closure with three patients having an additional vagotomy and gastrojejunostomy. The seventh patient had a jejunal patch placed over the perforation and this patch had to be removed ten days later because of duodenal obstruction. All of the above patients did well.

Thirteen patients had combined pancreatic duodenal injury and all six of the deaths occurred in this group. All 13 patients with this combined injury had at least one post-operative complication with pancreatitis being the most common.

Early diagnosis of this lesion is frequently hindered by the lack of obvious peritoneal irritation or readily apparent X-ray findings. Retroperitoneal air along the border of the right psoas muscle is usually present but seen only in retrospect. Early diagnosis is critical because the mortality rate rises precipitously if surgery is delayed for 24 hours.

In the Operating Room, the surgeon will typically see a right retroperitoneal hematoma mixed with small air bubbles and a distinct bile discolouration. These findings are diagnostic and necessitate a complete duodenal mobilization in order to properly identify and repair the perforation. The most critical decision that the surgeon must make is whether the pancreas is damaged severely enough to require pancreaticoduodenectomy. Three of our early mortalities may have survived if this procedure had been performed. Two patients in our series did have a pancreaticoduodenectomy and one of these patients died. This patient, however, had too many injuries to survive any operative procedure.

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Group Therapy With Schizophrenic Patients

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There is much literature on group sessions with well motivated neurotic patients but not much significant work has been published on group therapy with schizophrenic patients. Such therapy is undoubtedly in progress, especially at state and Veterans Administration hospitals.

This paper deals with impressions formulated while dealing primarily with schizophrenic patients for a brief period at a V.A. hospital. Since these are impressions they should not be mistaken for anything more than that; but they appear to be valid to the author and his co-workers. It is hoped that a dialogue will begin among group therapists dealing with schizophrenics so that we can progress from impressions to scientifically validated data.

The unit in discussion is a 20-bed closed ward at the Ann Arbor V.A. hospital (affiliated with the University of Michigan Department of Psychiatry). The unit is used primarily for actively psychotic patients, problem schizophrenics, suicidal patients and severely ill alcoholics. Patients are divided into two groups of 10 each according to date of admission rather than by diagnosis, although some balance is attempted at times: e.g., not placing too many depressed or alcoholic patients in one group. The groups are open-ended and as one patient is discharged another is admitted to the ward and to the group. Each group has three therapists — the staff psychiatrist and two psychiatry residents or the staff psychologist and two psychology trainees. Occasionally the chief nurse will take the place of one of the therapists. The groups meet for one hour a day five times a week.

Patients come to group unless they are unruly or akathisic. With chemical tranquillization we rarely have to exclude a patient from a group for more than several days. The only patients who are occasionally totally excluded from a group are short-term, poorly motivated alcholics for we feel that they do not add to, and often detract from, our group psychotherapy efforts. The vast bulk of the patients then consist, in decreasing order, of schizophrenics in the process of remission, actively psychotic schizophrenics, psychotic depressed patients, psychomotor epileptics, alcoholics and patients with brain syndromes.

Most of the patients belong to the lower socio-economic classes. It might be expected that patients from higher socio-economic classes with more formal education might present somewhat differently than the groups we are discussing, e.g., they would be more verbal, less concrete, have more expansive world-views, be able to see things more dynamically.

SOME CHARACTERISTICS OF OUR SCHIZOPHRENIC GROUPS

Fluctuating momentum: It is often very difficult to "get the session going," and once the session has gathered some momentum it often loses the momentum rapidly. This might be partially expected from the nature of the psychopathology; i.e., frequent isolation, withdrawal, suspiciousness, passivity of thinking, thought blocking, etc.

Association of psychopathology with a job problem: The patients tend to speak of their psychopathology as a "problem" which could be solved if only they could hold down a job or if they could get out and work. "Employment" is the metaphor most often chosen by our schizophrenic patients to express their feelings. The patients are often reluctant to speak about their interpersonal relationships at home or in the hospital. They appear outwardly to regard such dynamics as often being of little consequence compared with functioning well on the job. This may be in part because personal situations can be adapted to more easily than rigid working conditions: e.g., an employer is less liable to be accepting of deficiencies than is a patient's family.

A job also may be symbolic of our patient's masculinity and adequateness. Everyone can see outwardly how they are doing on the job but few know about what goes on in the privacy of the home or the self. Also, to hold down a job means being like all the normal people in the world.

THIS EMPHASIS on employment is often a major group resistance, a defense against discussing interpersonal relationships or inner conflicts. It may be difficult to ascertain when a real problem becomes a defense, but when a group consistently avoids topics such as sex, interpersonal relationships, feelings, fantasies or other material which we normally regard as important, the

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therapists must stop and reassess what is going on. Of course, the opposite may happen and in some groups preoccupation with sex, for example, may become a resistance in itself. What comes up for discussion is also influenced greatly by what the therapists covertly or overtly accept as being important or permissible.

ACCEPTANCE OF each other's ideas, feelings and behavior: The patients tend to accept each other's ideas, feelings and behavior readily. It often appears that even such blatant psycopathology as hallucinations or delusions of grandeur are often seen by the group as "within normal limits." Patients who are seen as being quite ill by the staff are frequently perceived as not being ill by the group.

Denial: Despite the fact that the ward is a closed one and even has locks on the window screens some patients deny that they are in a "mental institution." As soon as ego-alien symptoms abate the group members may no longer accept the fact that they are ill and will support each other in this belief. This is akin to a "flight into health" and may be seen with some neurotics, especially hysterics.

Lack of intergroup questioning: The group members frequently do not question each other very much. This may be in part because of a fear of criticism or because they honestly have no desire to open themselves up to the challenges of interpersonal relationships. This contributes to frequent silent moments during the sessions. The patients usually do not ask much or give much. They have a difficulty in caring about others and each patient stays in his own "space" until he is moved in on.

Acceptance of peer decisions: If the group actively takes part in helping each other in making decisions or in questioning attitudes we feel that the members accept this more readily than the therapist's comments. Schizophrenics are more likely to trust each other than the therapist.

TECHNIQUES

Horowitz and Weisberg[1] have recently published their techniques for the group therapy of acute psychosis. They attempt to establish and maintain group cohesiveness by supportive and confident remarks on the therapists' part, isolation within the group of agitated and paranoid patients "with their all too believable delusions," and a closing summary at the end of each session. They established participation by development of a patient therapist whose pro-therapy interventions exert pressure from within on recalcitrant patients, and by the therapists' "prophetic" statements that "the withdrawn patient would soon be participating in the group therapy." They discouraged self-impairing remarks by imposing defensive alternatives and by "enforcing by group pressure the patient's acceptance of modest for themselves." This is accomplished by reality oriented remarks addressed to the group by the leader. For instance, the therapist would state; "No, X is not God. He is not even more powerful than anyone else. . ." "Ward milieu also stressed small but frequent increases in physical freedom as recovery progressed. The authors also stress the importance of non-verbal communication"; the group feeling tone and attitude were influenced with great immediacy by the posture, direction of gaze, movement, and facial expression of the group leader."

We have found that most patients with acute psychosis generally do not remain acute very long under a regimen of chemotherapy, psychotherapy and involvement with the total ward programs. We have never had a group composed entirely of acute psychotics and it may be because of this that at times we utilize different techniques than those mentioned above. However, we use the previously mentioned paper as a point of reference for the discussion of our techniques.

WE TEND not to emphasize the therapist's authority nor to encourage great identification with him. Especially with paranoid patients we feel it best to dilute negative transference onto the group as a whole. Thus the therapist usually would not challenge a patient by saying, "No, you are not God." Rather we would encourage the patient to express his delusions and to have the group react to them. It is often exasperating when the group does not react as we would wish, but rather than directly confronting the patient we might say, "How does the group feel about Mr. X's statement that he is God?" We might call upon each group member individually to express an opinion. Sometimes the group has no "feeling" and it is best to try again another day. It is important to note that we set no rigid rules and upon occasion we might find it in the best interests of the patient to challenge him directly, albeit in a non-hostile way.

The fact that we do not foster much group identification with the therapist is inherent in our system which calls for three therapists, thus diluting identification with any particular one. Also, rather than to set up a "straw man" we would rather that group identifications came naturally. The most stable therapist (in terms of temporal permanence) often adopts a somewhat parental attitude. This, of course, is an idiosyncrasy of our group, yet one which we feel is helpful.

We often resort to calling people by name instead of throwing questions out for the group as a whole. Often we will ask one patient to comment about the statement of another patient in an attempt to develop some personal interaction. The difficulty with this technique is that the schizophrenic may easily misinterpret statements, feels slighted and withdraws. Once one patient withdraws then the others may follow suit also.

WE RARELY have resorted to isolating a patient within a group because of their agitated behavior or paranoid ideas. Agitated patients are excluded from the group until they are calm enough to participate. We encourage paranoid patients to express their delusions freely. If the group does not challenge the delusions after several exposures we might interject our own doubts to the group; e.g., "Does the group completely believe that Mr. X's wife is running around on him or is there something not quite right in the story we have been told?"

In our groups we do not formulate closing summaries at the end of each session. Often this is impossible to do because we rarely spend an entire session on just one or two topics. Also we feel that to summarize after each hour may lead to false but expedient generalizations. One cannot tie an incompletely misunderstood situation into a neat bundle. Closing summaries may also cause some "negative" patients to resent the fact that the therapist has the final say all the time. The therapist may also forget to include in his summary something which a patient feels is particularly important. Some patients may isolate throughout the session and be attentive for the last few minutes to listen to the summary.

Occasionally we make interpretations but we find that patients accept peer decisions more readily and encourage group decisions. More often than not the group, if guided gently, eventually picks up what we consider to be important. We then might say, "That's a very good point." Frequently the group will at first reject an interpretation or advice offered by one of the members. If we feel that this is a useful interpretation or proper advice we will bring this up at opportune moments and say, "You said so-and-so last week, Mr. X., I wonder how you and the group feel about that today."

Because our groups are open-ended we cannot really expect much true cohesiveness and this probably cuts down on interaction. Aside from changing group members, the residents and psychology trainees also change every six months. Optimally a closed group would probably be best. We feel that schizophrenics are not so much dependent as they are distrustful. They do not want to exchange what they have learned with difficulty. A trusting attitude develops better in a closed group and our groups would probably benefit from more true cohesiveness — which implies a willingness for mutual cooperation among patients.

WE ENCOURAGE the sharing of experiences among group members. There is nothing so reassuring to a patient than to meet another patient who had the same symptoms. We have found this to be especially true in the case of auditory hallucinations and bizarre bodily feelings when patients "compare notes" in groups and are somewhat reassured to discover that they are not alone in their misery.

We have not been impressed by the importance of the therapist's gaze, motions, etc. This may be of more significance with acute psychotics who distort their perceptions with great sensitivity. This works two ways, however, and the therapist may interpret some action on the part of a patient as a consequence of his (the therapist's) action when this is not the case at all.

Patients who do not actively participate are not pushed at first. Sometimes we do utilize "prophetic" statements that the patient will participate soon but more frequently we might say, "Would you like to share some of your thoughts with the group today?" If, after an appropriate period of time, the patient still does not participate we might ask the other group members to comment on why they think the patient is choosing not to participate. Usually this leads the patient into the conversation. Often the patient needs to be told privately that he should participate. The nurses and aides encourage the patients to bring their problems to the group.

Because we control pass privileges we can usually prevent a patient from making a decision "on the outside" that will be self-defeating. By granting passes we reinforce what we consider to be wise decisions made in group therapy. Hopefully, though, we guard against patients trying to please us in order to obtain a reward.

THE GROUP thus serves as a forum for the patient to "test reality" even though most of the members are not in perfect touch with reality. Patients can unburden themselves without fear of ridicule or overinterpretation. Schizophrenics have the opportunity to discuss the problems of the here-and-now, to socialize, to develop self-respect by respecting others in the same situation, to abandon their fears and delusions, to interact with staff and peers, and to plan for the future.

Through the process of socialization the patients learn to care about each other and to relate to each other. They learn to speak and perform the usual social amenities so that they can get by "on the outside" and be less conspicuous to "normal" people; i.e., a person's believing he is God only bothers people when that person talks about it or acts the part.

In group we try to present reality as a benign, benevolent experience much more useful than, and preferable to, unreality. The schizophrenics must learn, or relearn, to be realistic. In group we give him the opportunity to practice being realistic even if it only means mimicking the questions and remarks of the therapists.

Finally we get down to those traits which we meet in neurotic patients—doubts, childhood experiences, emotional difficulties, etc. Then group therapy essentially becomes what it is when dealing with neurotics except that schizophrenics may retreat into their schizophrenia when these problems are confronted. Schizophrenics want to play it "safe." Most would prefer to be left alone. Thus we must be careful of not scaring the patient away by moving in on him too fast.

GROUP THERAPY experiences should not and cannot be the only way for these patients to help themselves. The total ward environment and all programs must direct themselves to the major task in treating schizophrenics, that of learning or relearning how to live a productive and meaningful life.

The group sessions will be meaningful to the patient according to the ability and emphasis of the therapists. We get the impression that we are helping patients. Perhaps group psychotherapy, combined with appropriate chemotherapy and involvement in an active ward program, may be of greater value in treating schizophrenic patients than hithertofore expected.

REFERENCE

1. Horowitz, M. and Weisberg, P. Techniques for the group psychotherapy of acute psychosis. *International Journal of Group Psychotherapy,* 16:42, 1966.

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which reproductions will be made by Michigan Medicine.

6. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

7. Articles should ordinarily be less than four printed pages in length (3000 words).

8. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

9. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

10. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

11. It is understood that material is submitted for exclusive publication in Michigan Medicine.

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msms news

Michigan Mediscene

Feb. 12 — American College of Emergency Physicians, MSMS Headquarters, East Lansing, 6:00 p.m.
Feb. 24 — MSMS WOMAN'S AUXILIARY LEGISLATIVE DAY, Lansing (site to be selected)
Mar. 11 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.
Mar. 16 — American College of Emergency Physicians, Board Meeting, MSMS Headquarters, East Lansing, 5:00 p.m.
Mar. 18-19 — MSMS WOMAN'S AUXILIARY SPRING CONFERENCE, Midland
Mar. 25-26 — 9th ANNUAL CONFERENCE ON MATERNAL AND PERINATAL WELFARE, Pick-Durant Hotel, Flint
Apr. 13 — American College of Emergency Physicians, Board Meeting, MSMS Headquarters, East Lansing, 5:00 p.m.
Apr. 22 — MSMS COUNCIL, Towsley Center, Ann Arbor, 9:30 a.m.
Apr. 23-26 — MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY ANNUAL MEETING, Pontchartrain Hotel, Detroit
Apr. 30 — 1970 MSMS CONFERENCE ON MEDICAL ASPECTS OF HIGH SCHOOL SPORTS, Towsley Center, U-M, Ann Arbor (tentative)
May 6 — MICHIGAN CANCER COORDINATING COMMITTEE, MSMS Headquarters, East Lansing, 12:00 noon
May 6-8 — Michigan Public Health Association Annual Meeting, Statler-Hilton Hotel, Detroit
May 12-24 — 1970 Medical Staff-Trustee-Administrator Forum sponsored by the Michigan Hospital Association at Boyne Mountain Lodge
May 21-22 — MSMS ANNUAL MATERNAL HEALTH CONFERENCE, Kellogg Biological Station, Gull Lake
May 27 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.
June 17 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 12:00 noon
June 21-25 — American Medical Association Annual Convention, Chicago
July 23-25 — MSMS MID-SUMMER SESSION OF THE COUNCIL, Grand Hotel, Mackinac Island
July 23-25 — Midsummer Meetings of Medical and Health Organizations of Michigan, Grand Hotel, Mackinac Island
Sept. 20 — MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit, 9:30 a.m.
Sept. 20-24 — MSMS ANNUAL SESSION, Sheraton-Cadillac Hotel, Detroit
Sept. 23 — MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit, 8:00 a.m.
Sept. 25-Oct. 2 — American Academy of General Practice Scientific Assembly, San Francisco
Nov. 4 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 12:00 noon
Nov. 11 — MICHIGAN CANCER COORDINATING COMMITTEE, MSMS Headquarters, East Lansing, 12:00 noon
Nov. 29-Dec. 2 — American Medical Association Clinical Convention, Boston
Dec. 9 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

AMA's William Monaghan Praises MSMS Project

"To MSMS:

"The AMA appreciates the good work you are doing in Michigan in connection with the distribution of 'At Your Own Risk — The Case Against Chiropractic.'

"Some of the other state societies have ordered additional supplies of the book, but Michigan is the first to our knowledge that has urged all its county medical society presidents to secure and distribute copies of the book. It is an excellent idea, and we hope to suggest it to others as a good approach.

"Sincerely yours,"
William J. Monaghan
AMA Law Division

Mr. Tryloff New PCMA President

Warren F. Tryloff, associate executive director of MSMS, was installed as president of the Professional Convention Management Association at the annual meeting of the PCMA in San Francisco Jan. 4-8.

The national organization is a joint society of medical exhibitor representatives of pharmaceutical companies and medical societies. Mr. Tryloff previously served as treasurer of the PCMA and was elected president-elect in 1969. He will serve one year as president.

council minutes

Meeting of Dec. 10, 1969

MSMS Council Appoints 18 To Major, New Committees

LEGISLATIVE AFFAIRS — It was reported to The Council that 34 physicians had indicated their willingness to spend three successive days each in Lansing with the physician volunteer lobbying effort. Physicians have been assigned to 12 weeks of the Michigan legislative session.

RESOLUTION FOLLOW-THROUGH—The Council assigned 21 matters and resolutions from the 1969 Annual Session of the House of Delegates to appropriate committees for implementation.

COMMITTEE APPOINTMENTS — The Council appointed six physicians to the new MSMS standing Committee on Planning and Priorities and 12 physicians to a special Joint Task Force to implement a professional management study and reevaluation and reorganization of the Society. (See January News Extra)

BLUE SHIELD — It was reported to The Council that in accordance with the wishes of the House of Delegates, candidates for the Blue Shield board will be selected and announced earlier than in the past. Members of The Council were invited to suggest names for the nominating committee.

REGIONAL ADVISORY COMMITTEES — The Council approved nine recommendations by the County Societies Committee outlining areas of concern in setting up regional medical advisory committees which would benefit from MSMS policy direction. The Council approved recommendations (1) to leave the decision of what cases to accept for review to each review committee; (2) to permit insurance carriers or the government to defray the costs of review activity, at the discretion of the review committee, and with the understanding that the review committees may thus submit a bill to the insurance carrier; (3) to have a prior agreement form drawn up and published in *Michigan Medicine* and to leave the use of this form to the responsibility of the individual physician; (4) to have the regional medical review committees be appointed by the component medical societies on an annual basis and the chairman, size and representation of the committees left to the discretion of the individual committees; (5) to have each committee report to its component society, the referring insurance carrier and the physician involved; (6) to not describe the existence and method of operation of the medical advisory committees to the public at large; (7) to refer to the MSMS Committee on Constitution and Bylaws the question of whether the committees ought to be mentioned in local bylaws to give them legal and official status; (8) to have the new Committee on Utilization and Health Insurance Problems serve as an appeal body for decisions of the Medical Advisory Committees, as recommended by The Council chairman, and (9) to permit portions of Councilor Districts to form regional medical advisory committees.

BASIC SCIENCE LAW — The Council approved plans to have an interested legislator introduce a bill to amend the Michigan Basic Science Law so that its provisions would apply only to chiropractors and foreign-trained (except Canada) D.O.s and M.D.s but would not apply to any M.D. or D.O. who has received his degree in the United States or Canada.

RUBELLA CAMPAIGN — The Council urged all component medical societies to cooperate with the Michigan Department of Public Health in its program of giving rubella vaccine to school children in grades K through 3.

GROUP TRAVEL TOURS — The Council endorsed a proposal for an eight-day jet tour to Las Vegas and Los Angeles for MSMS members going to the Rose Bowl, agreed to join with the Michigan Association for the Professions in sponsoring a Caribbean Tour May 29-June 11 when the MAP Congress will be held on board ship, and agreed to have MSMS sponsor a trip to the Orient in October, 1970, immediately following the MSMS Annual Session.

MEDICAL SURVEY — The Council referred to the Committee on Governmental Medical Care Programs investigation of the costs and best methods for conducting a survey of the medical needs of the people in the inner city of Detroit and the facilities and services now available to meet these needs.

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welcome

New Members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Lynn W. Blunt, M.D., P.O. Box 2060, Ann Arbor 48106
Keith C. Burns, M.D., Univ. of Mich. Hosp., Ann Arbor 48104
Melih Erhan, M.D., Lock Box A, Caro 48723
George C. Evans, M.D., 4059 W. Davison, Detroit 48238
John W. Hall, M.D., Univ. Medical Ctr., Dept. of Urology, Ann Arbor 48104
Austin M. Katz, M.D., 140 Elizabeth Lake Rd., Pontiac 48053
Bruce H. MacPherson, M.D., 880 Woodward Ave. #111, Pontiac 48053
Richard K. Meils, M.D., 310 W. University Dr., Rochester 48063
Leonard J. Portner, M.D., Wm. Beaumont Hosp., Royal Oak 48072
B. C. Reddy, M.D., Pontiac General Hosp., Pontiac 48053
Charles W. Shipman, M.D., 2040 Indian Trails Blvd., Traverse City 49684
Donald F. Silver, M.D., 467 Fisher Bldg., Detroit 48202
Reginaldo Stanley, M.D., Wm. Beaumont Hosp., Royal Oak 48072
Berhan I. Tosuner, M.D., 1553 King George Bldg., Ann Arbor 48104
Pieter D. Vreede, M.D., Parke Davis & Co., Ann Arbor 48105
George E. Bryan, M.D., 2547 Ellis Road, Ypsilanti 48197
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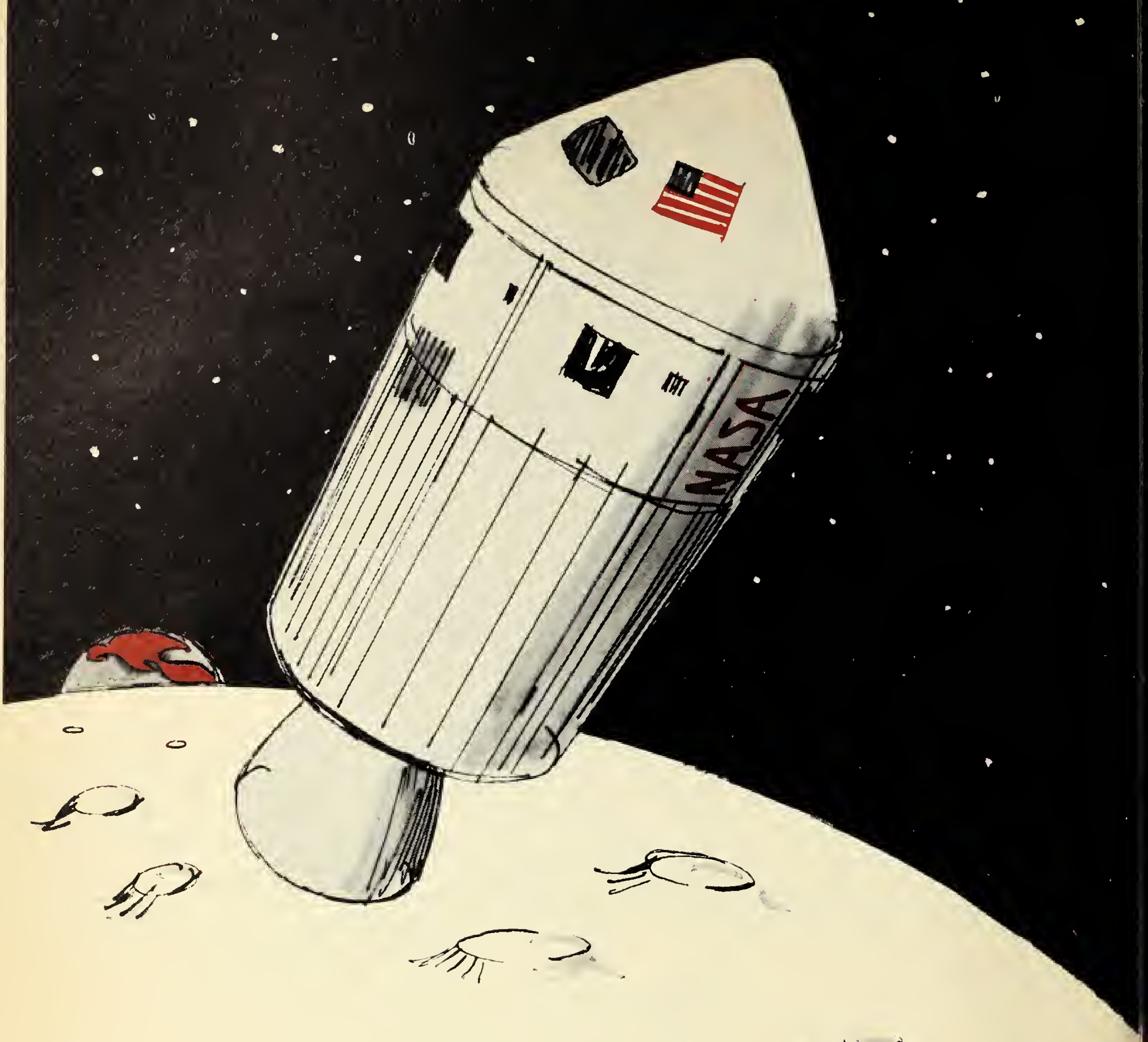

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about doctors

WALTER L. HOWLAND, M.D., AND WILLIAM G. GAMBLE, JR., M.D., BAY CITY,
were recently named members of the International Inflammation Club.

HANS FISCHER, M.D., STANDISH,
was named a fellow of the American College of Surgeons at the college's 55th Congress in San Francisco.

JAMES P. MULDOON, M.D., GRAND RAPIDS,
has been named president of the Michigan Proctologic Society.

HAROLD B. FENECH, M.D., DETROIT,
is new president of the Detroit Academy of Medicine for 1969-70. Other new officers include Gaylord S. Bates, M.D., Dearborn, president-elect, and George S. Fisher, M.D., secretary-treasurer.

TWELVE MUSKEGON COUNTY PHYSICIANS
are among 15 area residents who were recently honored by the Muskegon County Medical Society for a combined total of 703 years of health service to the community. Special plaques commemorating their 41 to 48 years each of service were presented to Helen S. Barnard, M.D., Muskegon; William S. Chapin, M.D., Muskegon Heights; Harold F. Closz, M.D., Muskegon; Frank W. Garber, Sr., M.D., Muskegon; Martha H. Goltz, M.D., Montague; Leland E. Holly, M.D., Muskegon; Marie Keilin, M.D., Muskegon; Vilda S. Laurin, M.D., Muskegon; Louis LeFevre, Jr., M.D. North Muskegon; William M. LeFevre, M.D., North Muskegon; Paul E. Medema, M.D., Muskegon and C. L. Oden, M.D., Muskegon.

WILLIAM JEND, JR., M.D., DETROIT,
has been designated the Wayne County Medical Society representative to the Wayne County Inter-Agency Council on Alcoholism.

DONALD D. WORCESTER, M.D., GRAND RAPIDS,
is a new fellow of the American Academy of Pediatrics.

JOHN GILROY, M.D., DETROIT,
is the new chairman of the Department of Neurology at Wayne State University, succeeding John Stirling Meyer, M.D., who left WSU on Sept. 1 to become chairman of neurology at Baylor University. Doctor Gilroy has been on the WSU faculty since 1963 and is a fellow of the American Board of Neurology and Psychiatry and the Royal College of Physicians of Canada.

DONALD E. FINCH, M.D., ONAWAY,
was honored recently by his northern Michigan community when it opened its new Finch Clinic, an outpatient facility named for the town's only physician. Town officials proclaimed "Finch Week" commemorating the 20th anniversary of Doctor Finch's coming to Onaway, and held a banquet. Townspeople credit Doctor Finch with the growth of their Russell Memorial Hospital. Estimates are that since Doctor Finch arrived in Onaway, he has delivered 1,100 babies, treated over 12,000 emergencies and had over 200,000 office calls.

VERNAL CAMBRIDGE, M.D., SAGINAW,
is one of eight directors of the Saginaw United Negro College Fund which recently conducted its annual drive for funds.

R. D. MUDD, M.D., SAGINAW,
was one of the speakers for the first annual Booster Dinner for the Saginaw Historical Society and Museum. He spoke on the History of Historical Associations in Saginaw.

MARY SOULE, M.D., ANN ARBOR,
who has served during the past year with the Michigan Public Health Service program at the University of Michigan, has been named the Oakland County Health Department's first woman deputy director of health. For 14 years, she had a private practice in obstetrics and gynecology in Omaha, Neb. She will assist in the planning, administration and evaluation of the county's public health program.

THE LATE BENJAMIN L. FRANKLIN, M.D., REMUS,
has been honored with the installation of a plaque in his name in the continuing education room at the Kelsey Memorial Hospital in Lakeview. Doctor Franklin's family established a memorial fund to provide equipment for the classroom during the hospital's recent building program.

(Continued on Page 140)

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Now a new 10% solution, Mucomyst-10, offers you the choice of prescribing a lesser concentration whenever you feel this is desirable. It provides added convenience and simplicity, particularly for your patients using nebulizing units at home.

By including Mucomyst-10 in the home management regimen, you can provide full mucolytic benefits for many of your patients with chronic bronchitis and emphysema complicated by tenacious secretions.

Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings: After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched carefully. If bronchospasm progresses, this medication should be immediately discontinued. Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied: Mucomyst-10 (acetylcysteine)**, a sterile 10% solution, in vials of 10 ml. and 30 ml.; **Mucomyst (acetylcysteine)**, a sterile 20% solution, in vials of 10 ml. and 30 ml.

MeadJohnson

LABORATORIES

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R. C. CROWELL, M.D., BENTON HARBOR,
who has been a surgeon for the Benton Harbor-St. Joseph area for 31 years, has accepted a post on the staff of the Southern California Permanente Medical Group in Los Angeles. He left St. Joseph the first week of January for his new work in diagnostic urology and teaching. He is a past president and secretary of the Berrien County Medical Society and has been chief of two area hospital staffs.

A. O. ABRAHAM, M.D., HUDSON,
retired Jan. 1 after nearly 35 years in general practice. He has a new position with the Jackson Doctors Emergency Service at Foote Hospital in Jackson.

MARTIN F. JONES, M.D., LANSING,
has accepted an appointment to the Scientific Advisory Board of the Kidney Foundation of Michigan. Doctor Jones is founder and director of the Hemodialysis Center at E. W. Sparrow Hospital, Lansing and is a faculty member with the Michigan State University College of Human Medicine.

ANTON J. SCHWARZ, M.D., MIDLAND,
has been named director of the Dow Chemical Company's Biological Laboratories at Zionsville, Ind., in addition to his present assignment of director of human health research and development for the Life Sciences Department.

BERNHARDT L. PEDERSON, M.D., BAY CITY,
has been elected to a three-year term as director of the Bay City YMCA. He joins William M. Follis, M.D., Bay City, on the YMCA board.

R. A. FRARY, M.D., MONROE,
soon will make his home at Eustis, Florida, where Dr. and Mrs. Frary have purchased a home. They enjoyed a long vacation trip to Nebraska, Black Hills, Sun City, and Florida. Doctor Frary long was active in MSMS committee work and as an officer of the Monroe County Medical Society.

THOMAS H. CARDINAL, M.D., CADILLAC,
is new medical director of the Associated Health Departments consisting of District Health Department No. 1 and Grand Traverse-Leelanau-Benzie District Health Department serving 93,000 persons in a 7-county jurisdiction. Doctor Cardinal has been in general practice until now.

MARJORIE KARKER,
now of Sun City, Fla., and a former MSMS staffer, led a committee of 100 volunteers to work with physicians on a Sun City community glaucoma screening project. She is president of the Sun City Chapter of the American Association of Retired Persons.

JOSEPH C. DENNISTON, M.D.,
formerly of Butlerville, Ind., has been named medical superintendent of the Caro State Home and Training School. Former superintendent of the Muscatatuck State Hospital in Butlerville, he succeeds Bettye McFarland, M.D., who resigned the Caro post in June, 1969. Doctor Denniston is a former director of the State Bureau of Services for the Mentally Retarded of Pennsylvania and is a graduate of Tufts Medical School.

HENRY KLOS, M.D., BENTON HARBOR
was elected vice president of the Twin Cities Area Community Services Council at the recent annual meeting. The Council is the planning division of the United Fund.

DOCTOR TOWSLEY NAMED TO HEALTH HALL OF FAME

Doctor Towsley

Harry A. Towsley, M.D., Ann Arbor, president of the Michigan Foundation for Medical and Health Education and chairman of the MSMS Committee for Postgraduate Medical Education, has been named to the Michigan Health Council's Health Hall of Fame.

Former president of the Michigan Health Council, the Michigan United Fund and the Michigan and American Academies of Pediatrics, Doctor Towsley was cited by the Health Council for his international repute in the organization of postgraduate medical seminars for physicians.

He was also recognized for his substantial organizational and monetary leadership in developing the C. S. Mott Children's Hospital and the Towsley Center for Continuing Medical Education at the University of Michigan, where he is professor of pediatrics and chairman of the Department of Postgraduate Medicine in the Medical School.

He also suggested programs for training pediatric assistants, which have been adopted by colleges and universities across the country. His prime interests, summarizes the Health Council, have been "to make Michigan babies the healthiest and Michigan doctors the best informed."

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.

The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.

A realistic approach to pain relief

Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

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Contraindications: Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention), skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk t minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derma-

Sandy sails again!
After an arthritic flare-up.

His rheumatoid arthritis flared out of aspirin control. It meant weeks of pain, stiffness, swelling and tenderness...and a lot of sun and wind that somebody else took advantage of.

Next time, after aspirin, consider Butazolidin alka:

prompt anti-inflammatory effectiveness
short trial period
low maintenance dosage
usual dosage: 1 capsule q.i.d. initially, then 1 or 2 daily

Butazolidin® alka Geigy

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings and contraindications. Read the prescribing information. It's summarized below.

Stevens-Johnson syndrome, 's syndrome (toxic necrotizing ermolysis), or a generalized gic reaction similar to serum ess may occur and require anent withdrawal of medica- Agranulocytosis can occur ienly in spite of regular, repeated al white counts. Stomatitis rarely, salivary gland enlarge- t may require cessation of treat- t. Such patients should not ve subsequent courses of the . Vomiting, vertigo and languor occur. Leukemia and leukemoid tions have been reported. While lefinitely attributable to the , a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily. In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-C

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
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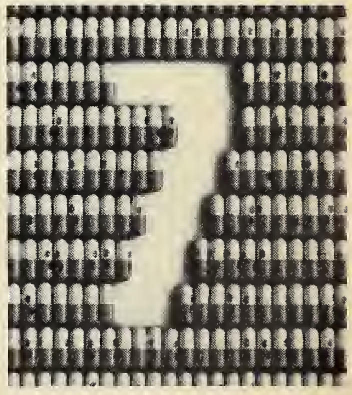
Ardsley, New York 10502



If it doesn't work in a week, forget it.

symptoms of mixed anxiety-depression are rarely clear-cut

but they are often a clear indication for

Mellaril®

(thioridazine)

25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

medical care programs

Fraud The Target Of New Federal Rulings

BY HERBERT MEHLER
STAFF SECRETARY
MSMS COMMITTEE ON
GOVERNMENTAL-MEDICAL CARE PROGRAMS

NEW HEW REGULATIONS

Beginning April 1, 1970 the appropriate state agency will be required to set up and maintain methods of identifying and prosecuting Medicaid fraud by printing in bold face type on all provider claims forms above the claimant's signature: "This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claim, statement or document, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

* * * *

THE NATIONAL SCENE

James H. Cavanaugh, Ph.D., HEW Deputy Assistant Secretary for Health and Scientific Affairs, recently told a symposium on health care costs sponsored by the National Pharmaceutical Council that major change is urgently needed—"substantive change in the patterns of health care delivery, in the financing of health care, and the training and utilization of health manpower, and in the respective roles of the public and private components of the health system." He told the group that the Nation's health industry must make the present system work or the government may take over and that "events . . . and decisions . . . are being made in Washington that to me indicate very clearly a pattern that is going to produce changes—dramatic, fundamental, and urgently needed changes in the delivery of health care." Doctor Cavanaugh further warned "groups like those represented here today are facing a wholly new task, the most critical task that you have ever faced. You are being asked to keep the pluralistic, public-private health care system from dying, from being swept away by its own failure to serve the health demands of the American people."

CHAMPUS

The Director of the Office for the Civilian Health and Medical Program of the Uniformed Services has been asked by the Federal House Armed Services Subcommittee to submit a list of all MDs receiving $25,000 a year or more under the program. CHAMPUS will submit a coded list—no names—estimated to total 100.

* * * *

EXTENDED CARE FACILITIES

The President of the American Nursing Home Association recently reported that retroactive denial of benefits, contradictions in applying policies and complicated, tedious auditing procedures have compelled hundreds of Medicare-certified extended care facilities to either drop out of Medicare or scale down the level of participation.

* * * *

MEDICAID

This program was enacted as Title XIX of the Social Security Act in July, 1965 as a Federal-State system of medical assistance to those who receive aid under Federal-State welfare programs for the aged, blind, disabled and families with dependent children. Those whose resources prevent their qualifying for aid but who nevertheless do not have the means to meet their medical expenses, i.e., the "medically needy" are also covered in Michigan.

State programs must provide services in each of five categories: In-Patient Hospital Services; Out-Patient Hospital Services; Physician's Services (whether furnished in an office, hospital or elsewhere); Skilled Nursing Home Services for Adults; and Laboratory and X-ray Services.

(Continued on Page 146)

IN MICHIGAN

Administered by the State Department of Social Services, Lewis Cass Building, Lansing, Michigan 48913.

Those eligible:

Residents of the State who need medical care and cannot pay for all or part of it. This includes people eligible to receive public assistance under the various programs for the aged, blind, disabled, and families with dependent children (to age 21); the medically needy and all "medically needy" people under 21.

Medical Care Provided:

In-Patient Hospital Services; Out-Patient Hospital Services; Other Laboratory and X-ray Services; Skilled Nursing Home Services (18 or older); Physician's Services; Pharmaceutical Services; Other Practitioner Services as specified; Home Health Care Services; Transportation, limited to ambulance service to and from hospital when medically necessary; In-Patient Hospital and Skilled Nursing Home Services for over 65 in tubercular or mental institutions.

* * * *

MEDICARE — QUESTION AND ANSWER

Question: A Medicare beneficiary is hospitalized and *on* the third day of his stay he is transferred to a nursing home. Is his stay at the home covered by Medicare?

Answer: No. A recent Social Security ruling points out that the patient has to be in the hospital *at least three days* before entering the home. In applying this rule, the day he enters always counts even if he is there only part of the day, but the discharge *is never counted.* Therefore, if the patient is transferred on the third day of the stay, he has only been hospitalized two days.

* * * *

MEDICARE RULINGS

A patient whose entitlement to nursing home benefits is exhausted doesn't requalify for re-entering a hospital during the same spell of illness.

The "custodial care" exclusion bars payment on behalf of a woman who is in a nursing home because of senility.

Doctor's services and an orthopedic brace provided outside the U.S. are not covered.

Payments are now allowed a doctor for treating his widowed stepmother.

! MARK THESE DATES !

MIDWEST CLINICAL CONFERENCE
of the
CHICAGO MEDICAL SOCIETY

March 1-4, 1970

SHERMAN HOUSE CHICAGO, ILLINOIS

Outstanding Lectures and Panels
Continuous Medical Film Programs
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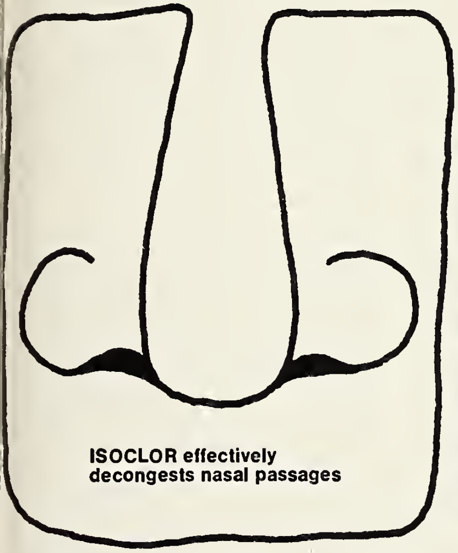
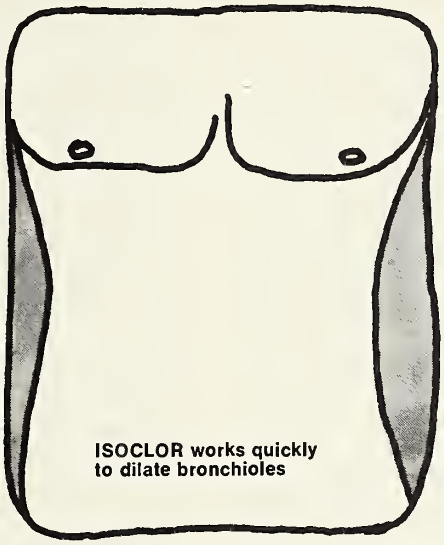
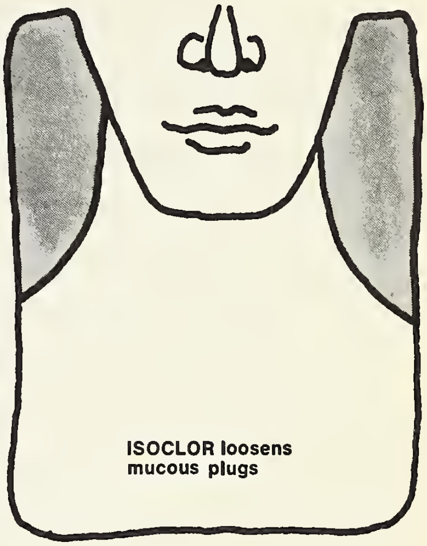
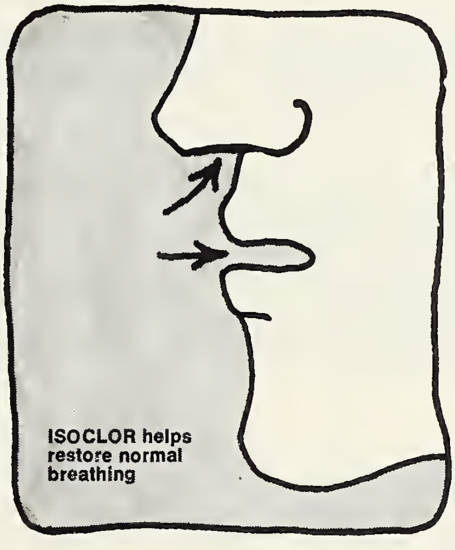
HERE ARE THE COLD FACTS:


ISOCLOR effectively decongests nasal passages

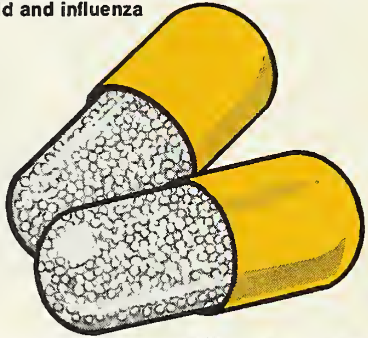

ISOCLOR works quickly to dilate bronchioles


ISOCLOR loosens mucous plugs

ISOCLOR relieves runny eyes


ISOCLOR helps restore normal breathing

ISOCLOR promptly and effectively combats symptomatic miseries of the common cold and influenza



ISOCLOR helps patients face the cold facts

ISOCLOR®

Isoclor provides quick, long lasting relief of respiratory congestion and discomfort brought on by common colds, influenza, and allergies. Isoclor contains chlorpheniramine maleate — one of the most potent and safest antihistamines. And pseudoephedrine HCl — a decongestant bronchodilator providing effective and long lasting relief for the entire respiratory tract. Both work to extend the range of relief.

COMPOSITION: Each tablet or 2 teaspoonfuls of liquid contains:
Chlorpheniramine Maleate .... 4 mg.
Pseudoephedrine HCl .... 25 mg.

Each ISOCLOR Timesule contains:

Chlorpheniramine Maleate .... 10 mg.
Pseudoephedrine HCl .... 65 mg.
In a special pellet form providing both prompt and sustained effect.

INDICATIONS: For symptomatic relief of colds, hay fever, allergic conjunctivitis, perennial rhinitis of allergic origin and sinusitis. Opens nasal, sinus and bronchial passages orally.

CONTRAINDICATIONS: Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease.

PRECAUTIONS: Use with caution in patients suffering with hyperthyroidism. Patients susceptible to the soporific effects of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CAUTION: Federal law prohibits dispensing without prescription.

SUPPLIED: Tablets: Bottles of 100 and 1000. Liquid: 4 oz. bottles, pints, and gallons; Timesules: Bottles of 50, 250, and 1000.

DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

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ancillary

Survey of Doctors' Postgrad Needs Being Analyzed

A survey of 1,600 Michigan physicians to determine their evaluation of current postgraduate medical education programs will have "a great deal of significance for postgraduate medicine and education not only in Michigan but also education nationally," predicts its physician co-director.

Neal A. Vanselow, M.D., Ann Arbor, associate professor of internal medicine and associate professor of postgraduate medicine at the U-M, reports that the survey is now being completed and the results analyzed, much of them by computer.

The preliminary report was presented before a mid-December meeting of the MSMS Committee on Postgraduate Medical Education, but "it will be several months yet before the full report will be ready," according to Doctor Vanselow.

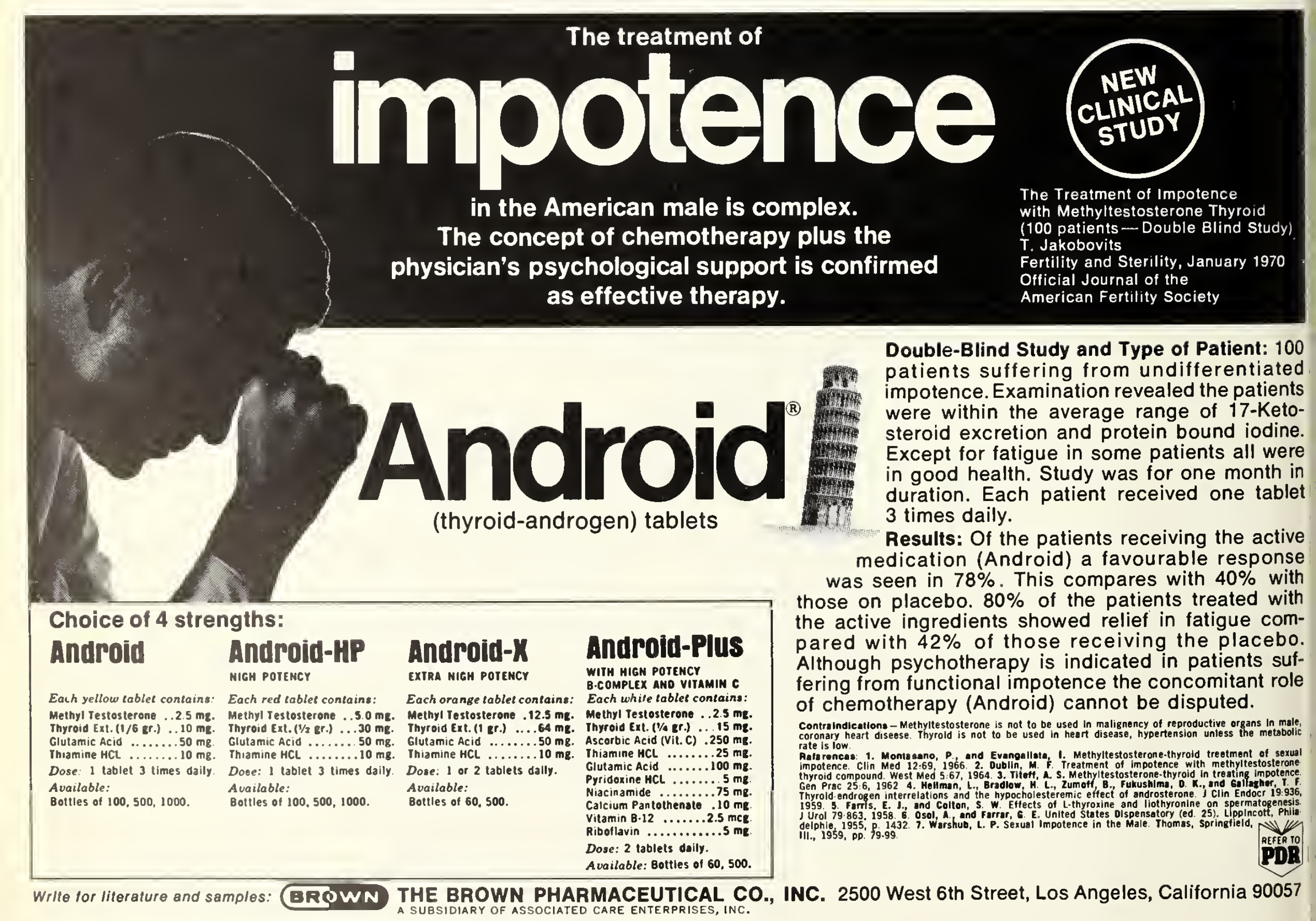
The data is being analyzed in order to compare responses from different regions of the state, from different age groups and different specialties, reports Doctor Vanselow.

"We are very, very pleased with the excellent return from the M.D.s and D.O.s we surveyed," he said. Approximately one in six Michigan doctors received the survey and 88 per cent of them returned it completed, with 69 per cent of the surveys comprising usable data.

Results of the study will be printed in a series of articles in future issues of *Michigan Medicine.*

The survey was proposed by the MSMS Committee on Postgraduate Medical Education, authorized and granted by the Michigan Association of Regional Medical Programs and drawn up by the Center of Research for the Utilization of Scientific Knowledge at The U-M.

The questions are designed to reveal physicians' attitudes toward present postgraduate medical edu-



The treatment of
impotence
in the American male is complex.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society

Android®
(thyroid-androgen) tablets

Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Keto-steroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android
Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
NIGH POTENCY
Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA NIGH POTENCY
Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGN POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL ....25 mg.
Glutamic Acid ....100 mg.
Pyridoxine HCL ....5 mg.
Niacinamide ....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 ....2.5 mcg.
Riboflavin ....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications — Methyltestosterone is not to be used in malignency of reproductive organs in male, coronary heart diseese. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treetment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-endrogen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphie, 1955, p. 1432. 7. **Warshub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Write for literature and samples: BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057
A SUBSIDIARY OF ASSOCIATED CARE ENTERPRISES, INC.

cation offerings, toward what they would like offered in the future, what things prevent them participating in postgraduate educational programs, what things motivate them to participate in postgraduate programs and their perception of their own competence.

Doctor Ostrander, Dentist, Elected Health Council Head

F. Darl Ostrander, D.D.S., M.S., Ann Arbor, has been elected president of the Michigan Health Council, succeeding E. Gifford Upjohn, M.D., Kalamazoo, who held the post during 1969.

Doctor Ostrander is a professor in the University of Michigan School of Dentistry, a former president of the Michigan Dental Association, the American Dental Association and the Michigan Association of the Professions.

Other new MHC officers include Winston Schuler, Marshall, president-elect. Re-elected officers and trustees include Hugh W. Brenneman, East Lansing, secretary; John C. McCabe, Detroit, treasurer; John A. Doherty, East Lansing, assistant treasurer; and trustees Austin Smith, M.D., Detroit; Marvin L. Niehuss, Ann Arbor; E. Gifford Upjohn, M.D., Kalamazoo, and Otto K. Engelke, M.D., Ann Arbor.

Newly elected trustees are Herman Glass, Southfield, and Lionel F. Swan, M.D., Detroit.

Principal projects of the Michigan Health Council continue to be the recruitment of students into health professions and occupations, the placement of physicians and dentists in Michigan communities where there is a need and the coordination of the programs of the Michigan Council on Smoking and Health.

DOCTOR DAVEY AGAIN LEADS TB ASSOCIATION

Winthrop N. Davey, M.D., Ann Arbor, will continue to serve during 1970 as president of the Michigan Tuberculosis and Respiratory Disease Association. He began the second year of his two-year term at the MTRDA's recent Annual Meeting at Kellogg Center, East Lansing.

Other physicians serving as officers of the MTRDA are Walter A. Meier, M.D., Monroe, Monroe County health officer, second vice president; Trustees-at-large James Acocks, M.D., Marquette; Winona Barrows, M.D., Kalamazoo; Raymond Engelman, M.D., Flint; James Lawrence, M.D., Kalamazoo, and Edward Nedwicki, M.D., Allen Park. Representative Trustees include Bernard Berman, M.D., Pontiac; E. Osborne Coates, Jr., M.D., Detroit, and Don Dosh, D.O., Flint.

(Continued on Page 150)

★

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DETROIT WOMEN DOCTORS LEADERS IN NATIONAL MEETING

Michigan woman physicians participated in the American Medical Women's Association annual meeting in Cincinnatti recently.

The Detroit representatives to the meetings included Delores Shalfoon, MD, president of the Blackwell (Detroit) Chapter of AMWA, who appeared as a panelist on Sex Education; Marjorie Peebles-Meyers, MD, Chairman of the Resolutions Committee; and Clara Raven, MD, Chairman, Public Health Committee.

The AMWA has had special interest in several social problems, namely;

1. Adequate household help with tax relief to be sought;
2. Care of dependents such as children and aged;
3. Areas of discrimination for women;
4. Opportunities for women physicians.

Doctor Knights Leads Michigan Pathologists

Edwin M. Knights, Jr., M.D., Southfield, is new president of the Michigan Society of Pathologists. He was installed at the pathologists' Annual Business Meeting Dec. 14.

New president-elect is Gerald Fine, M.D., Detroit. Other new officers include A. R. W. Climie, M.D., Detroit, secretary-treasurer; and trustees Harold E. Bowman, M.D., Grand Rapids; Murray R. Abell, M.D., Ann Arbor, and Leo Walker, M.D., Lansing.

U-M MEDICAL STUDENT IN CHARGE OF PROGRAM FOR SAMA CONFERENCE

Joel Morganroth, a senior student at the University of Michigan, is chairman of the planning and program committee for the Student American Medical Association's Second National Student Medical Education Conference scheduled Feb. 5-7 in Chicago.

Mr. Morganroth is also scheduled to discuss attitudes and skills required in a university center at the opening session of the conference, which is to be held in conjunction with the American Medical Association's Annual Congress on Medical Education.

DOCTOR BLACKHURST APPOINTED TO NEW STATE ADVISORY GROUP

Robert T. Blackhurst, M.D., Midland, has been appointed by Michigan Secretary of State James M. Hare to the new Medical Evaluation and Advisory Group of the Michigan Department of State.

Expected tenure of the group is through fiscal year 1970-71.

Establishment of the group, in compliance with minimum performance standards resulting from the National Highway Safety Act of 1966, "marks the first, formalized attempt to aggregate and bring the wisdom, practical experience and leadership of the medical and allied health professions of the state to bear on a truly quantum issue—traffic safety," noted Mr. Hare in making the appointment.

Doctor Blackhurst is chairman of the MSMS Committee on Eye Care.

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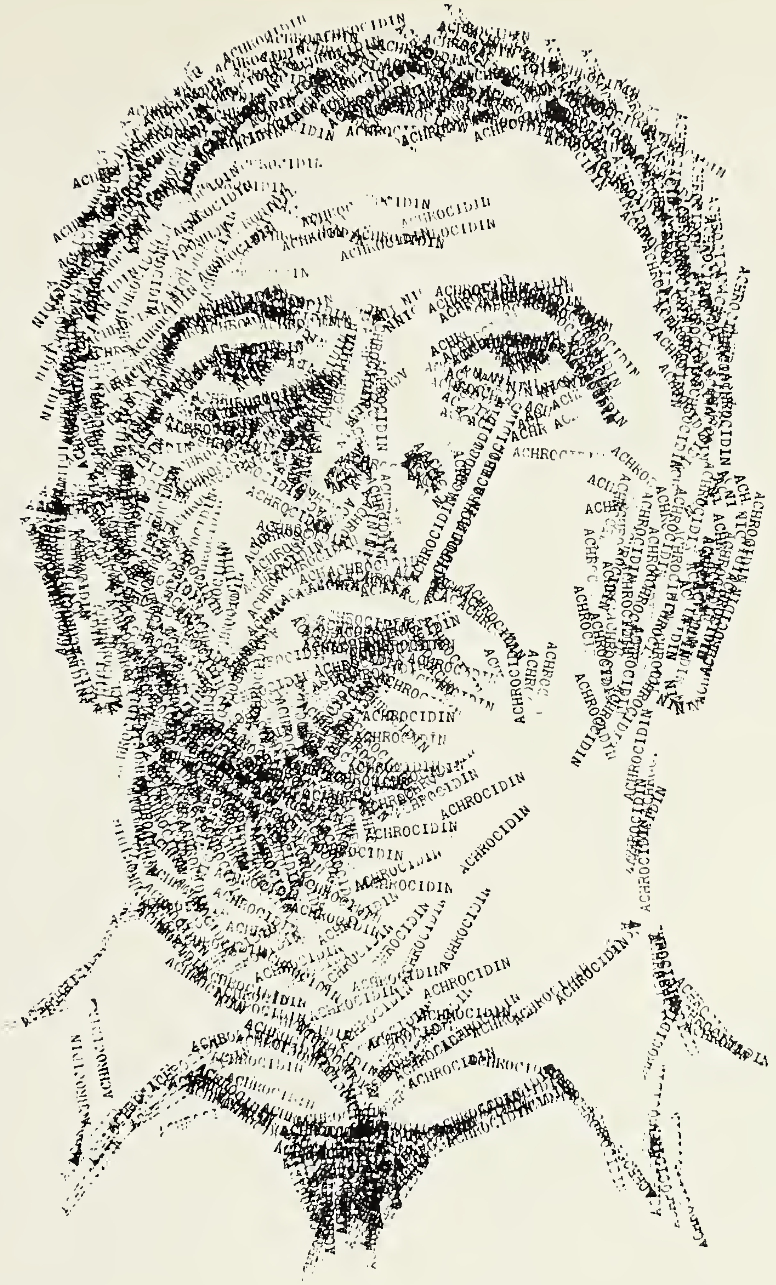

Achrocidin® Tablets and Syrup

Tetracycline HCl–Antihistamine–Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl–Antihistamine–Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.
Upon adverse reaction, stop medication and treat appropriately.

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Gov. Milliken: Michigan Must Find Key To Public Action on Mental Health

(The following statements were taken from a speech given by Gov. William G. Milliken at the annual meeting of the Michigan Society for Mental Health, in Lansing.)

We've come a long way since the mentally ill were put away in fortress-like institutions and forgotten. Through the efforts of organizations like your own, public understanding of mental illness and compassion for the mentally ill has increased tremendously. And with this wider understanding has come improved care of mental patients.

I wish it were as simple as all that. What I have said about heightened public interest in the subject and deeper understanding of it is true, but that is only the bright side of the coin.

THE TRAGEDY OF mental health care in this country today is that public awareness of the problem has not been matched by public support of mental health programs.

What does it take to arouse the people? Frankly, I don't know. The press has repeatedly shed light on conditions in the institutions. Legislative committees have probed through these buildings, many of which are old and dark and cramped. Concerned citizens from nearby communities visit them to bring light from the outside into the patients' dark lives. But despite all of this, more needs to be done.

We must find the key to unlock the public conscience and transform talk into action.

As a result of improved diagnosis and treatment in Michigan state hospitals for the mentally ill, we are reducing our resident patient population at the same time that our admissions per month are increasing. Our resident patient population in hospitals for the mentally ill has been reduced from over 17,000 in 1962 to about 12,000 in 1969. Present admissions have now leveled off to approximately 750 per month with about the same number of releases, indicating for the present a balanced system.

We have seen, since 1963, the planning and construction of the Muskegon Regional Retardation Center. We have expanded the capacity at Plymouth State Home and Training School, more than doubling resident accommodations.

Seven state hospitals now provide special treatment programs for emotionally disturbed and mentally ill children. The Department's Hawthorn Center has been cited as a national leader in development of effective out-patient and in-patient services. Hawthorn is also a major residency training center for child psychiatrists. Now, children's hospitals at Ypsilanti and Pontiac have been opened in the last three years, and Traverse City's will be ready for occupancy soon. Despite these improvements, the demand for admissions has continued to increase. As of June 30, 1969, there were 124 children awaiting admission — only 26 fewer than on the same date in 1967.

THE DEPARTMENT OF Mental Health is currently completing a reorganization which promises to improve the quality and quantity of client services.

In my fiscal 1969 budget, I requested and the Legislature appropriated $200,000 for an in-depth review and rewrite of the mental health statutes. This money was appropriated to the Legislative Council to carry out such a review. To assist the Council, I have also appointed a Blue Ribbon Governor's Commission on Mental Health Program and Statute Review* to work closely with the Legislative Council in modernizing Michigan's mental health laws.

PROGRESS IN MENTAL health today requires of us a willingness to change and a common commitment to assure better health for everybody.

That system, reinforced by your efforts, has worked well for us in the past. I hope that all of us — in government and private institutions — will rededicate ourselves to the goal of quality health care for every American wherever he lives and whatever his station in life might be.

A society that does not care tenderly for its sick is sick itself. A society that puts mental health far down on its list of priorities endangers its own mental well-being.

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*Editor's Note: Four MSMS members are among the Michigan leaders appointed by the Governor to the Mental Health Program and Statute Review Commission. They are David B. Ruskin, M.D., Saginaw; Benjamin Jeffries, M.D., Detroit; William Harrelson, M.D., Kalamazoo, and William Anderson, M.D., Lansing, director of the Michigan Department of Mental Health.

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antiinflammatory
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IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

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COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.

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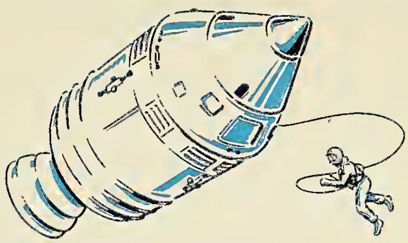

Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

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For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

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Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

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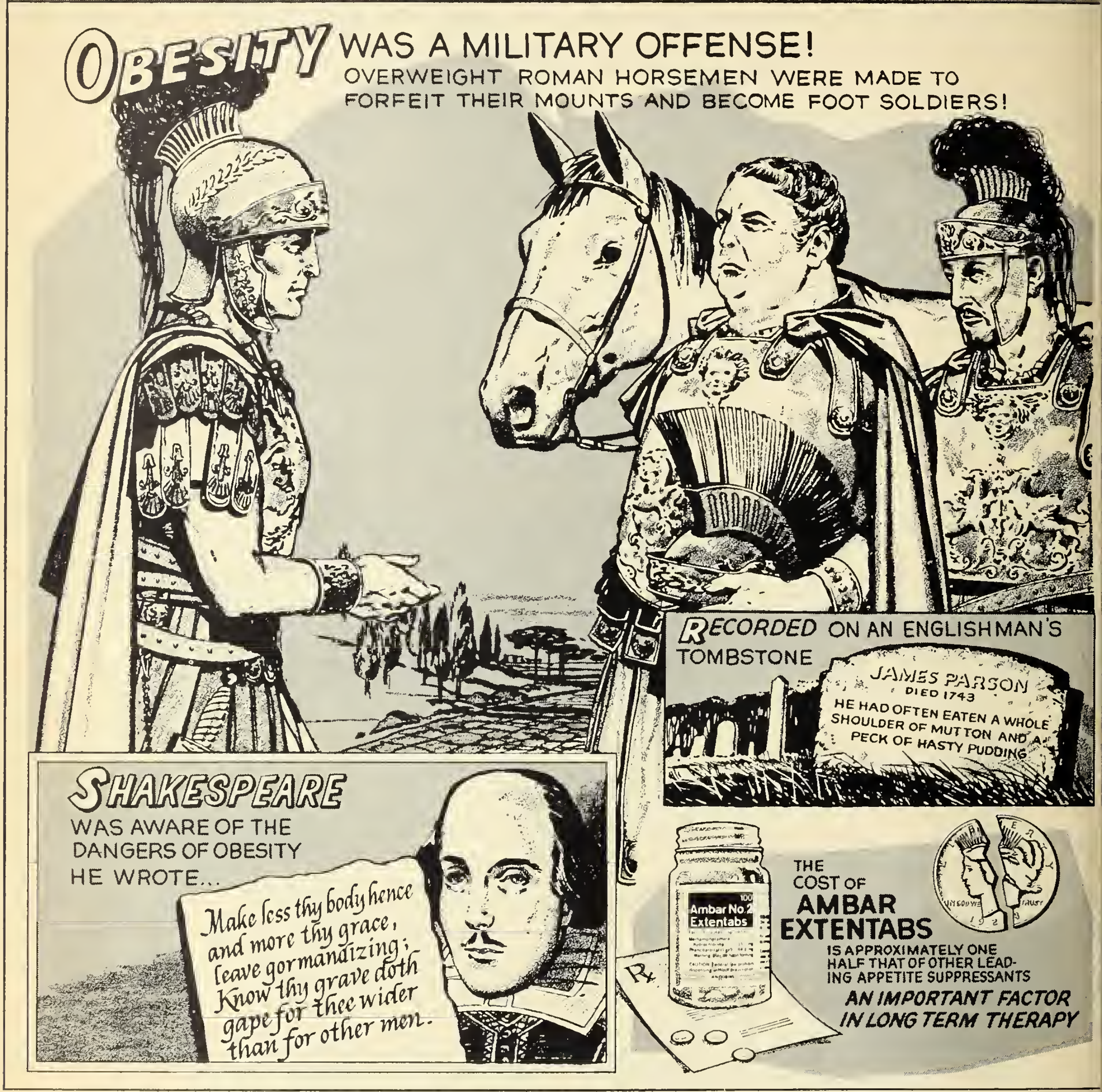
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OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!
RECORDED ON AN ENGLISHMAN'S TOMBSTONE
JAMES PARSON DIED 1743 HE HAD OFTEN EATEN A WHOLE SHOULDER OF MUTTON AND A PECK OF HASTY PUDDING
SHAKESPEARE WAS AWARE OF THE DANGERS OF OBESITY HE WROTE...
Make less thy body hence and more thy grace, leave gormandizing; Know thy grave doth gape for thee wider than for other men.
Ambar No. 2 Extentabs
THE COST OF AMBAR EXTENTABS IS APPROXIMATELY ONE HALF THAT OF OTHER LEADING APPETITE SUPPRESSANTS
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methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

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BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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Each Kapseal contains: ascorbic acid, 500 mg.; thiamine mononitrate, 25 mg.; riboflavin, 15 mg.; pyridoxine hydrochloride, 10 mg.; cyanocobalamin, 5 mcg.; niacinamide, 100 mg.; *dl*-panthenol, 20 mg.; Taka-Diastase® (Aspergillus oryzae enzymes), 2½ gr.

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PRECAUTIONS: *Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with* BENYLIN EXPECTORANT *should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing* BENYLIN EXPECTORANT.
ADVERSE REACTIONS: *Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.*
PACKAGING: *Bottles of 4 oz., 16 oz., and 1 gal.*
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PARKE-DAVIS

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PRECAST CONCRETE panel for the 22-story administration building is lifted into place (left). The panels will provide the "skin" for both the computer building and the administration office tower.

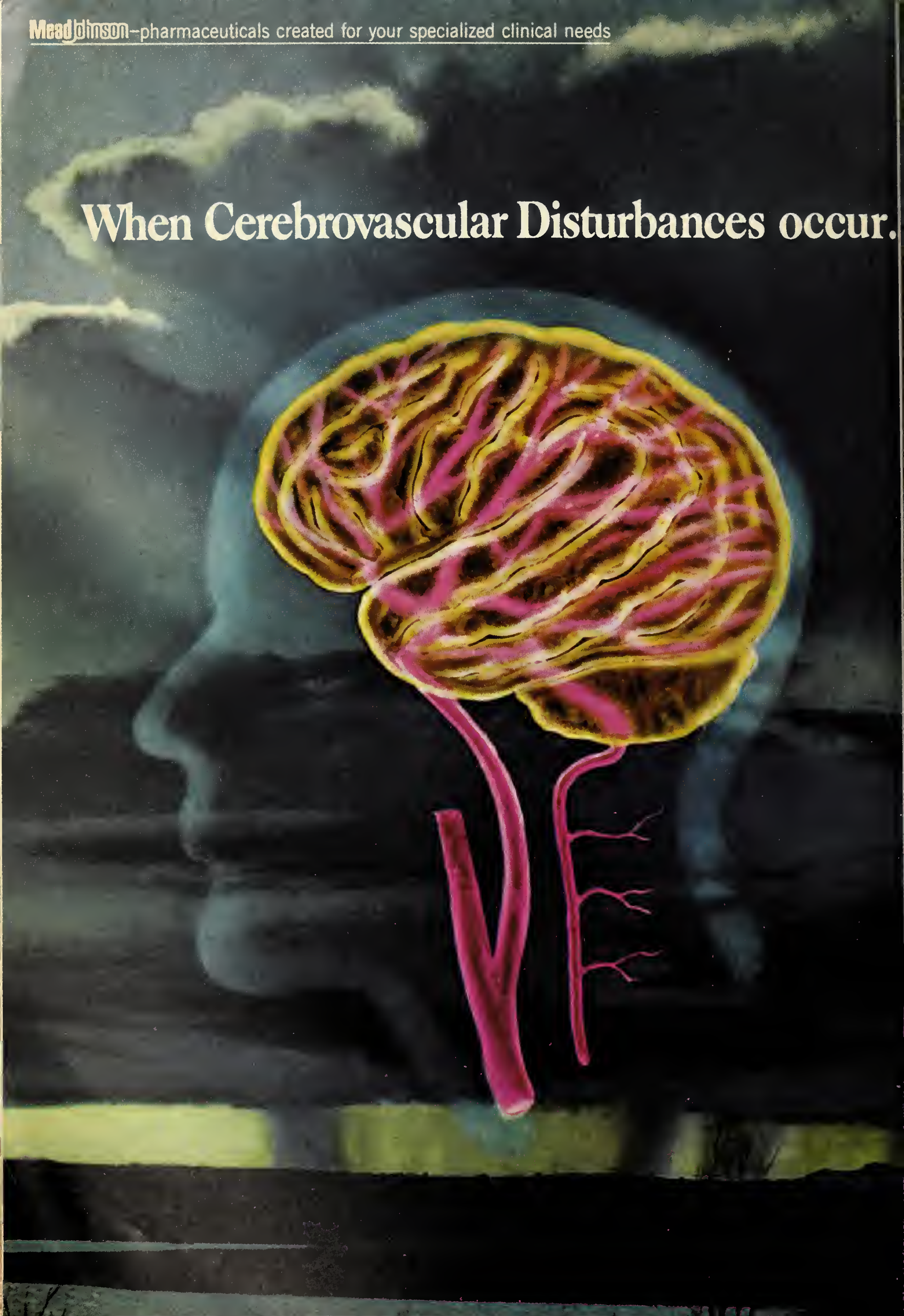
Progress Report On Service Center For "The Blues"

Photos on this page outline the progress in downtown Detroit of construction of a towering new profile in the city's skyline — a 22-story structure highlighting a three-building complex that city planners have called the "Gateway to Detroit." The "Gateway" is the $32 million service center that Michigan Blue Cross-Blue Shield are constructing on an 11½ acre site.

The center will enable the two health care public service organizations to consolidate in one location operations they currently carry on in nine separate Detroit buildings. It will provide working space and auxiliary facilities for more than 4,000 employees, and will include the tower housing BC-BS's administrative functions, a two-story computer support facility and a five-deck parking garage.

WORKERS BOLT the precast concrete panels directly to the administration tower structural steel (left). They paneled first the lower six floors on the eastern side of the tower, then the first 10 floors on the western side, then the next 10 floors of the eastern side and so on, to prevent the steel skeleton of the building from tilting slightly, due to the weight of too many panels on one side.

DETROIT EDISON workers lay pipe in the middle of East Lafayette Blvd. in Detroit to bring steam to the Blue Cross-Blue Shield center.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...with episodes of vertigo, headache, confusion, sensory loss, slurred speech, consider

VASODĪLAN®

(ISOXSUPRINE HCl)

to help relieve symptoms by preventing vasospasm and increasing cerebral blood flow

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ough not all clinicians agree on the value of vasodilators in vascular disease,[1] *several investigators*[2-5] *have reported favorably on the effects of*
suprine on cerebral blood flow. Effects have been demonstrated both by objective measurement[2,5] *and observation of clinical improvement.*[2-4]
ications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease),
naud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic).
nposition: VASODĪLAN tablets, isoxsuprine hydrochloride 10 mg. **Dosage:** Oral—10 to 20 mg. (1 or 2 tablets) t.i.d. or q.i.d. **Contraindications**
Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial
ding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10
or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete
ails available in product brochure from Mead Johnson Laboratories **References:** (1) Fazekas, J. F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut,
R., and Savarese, C. J.: Angiology *15:*No. 2 (Feb.) 1964. (2) Horton, G E., and Johnson, P C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson,
., and LePere, D M · Angiology *11*:190-192 (June) 1960 (4) Dhrymiotis, A D , and Whittier, J R.: Current Therapeutic Research *4*:124-128 (April)
2 (5) Whittier, J R.: Angiology *15*:82-87 (Feb) 1964

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medicolegal

(Editor's Note: The following articles are quoted from the AMA CITATION newsletter of Dec. 1, 1969, prepared by the AMA Law Department.)

PHYSICIAN-PATIENT PRIVILEGE NOT WAIVED IN INSURANCE CASE

The widow of a man insured under a life insurance policy did not waive the physician-patient privilege by submitting a letter from the man's attending physician stating that he had treated the deceased for a cardiac condition which was under fair control and did not prevent him from working. The ruling was handed down by the Supreme Court of Michigan.

The insurance company sought to take the deposition of the attending physician because they claimed material misrepresentation regarding the condition of the deceased's health on his application for insurance.

The court affirmed a lower court ruling that the physician-patient privilege had not been waived and that the deposition could not, therefore, be taken, because a true waiver is an intentional, voluntary act and cannot be implied. The controlling statute describes only one circumstance where a patient filing suit shall be "deemed" to have waived the privilege, and that is when a patient "shall produce any physician as a witness in his own behalf" in a suit for personal injuries or malpractice.— *Kelly* v. *Allegan Circuit Judge,* 169 N.W.2d916 (Mich., Sept. 3, 1969)

TRIAL ORDERED ON DISCOVERY DOCTRINE IN MICHIGAN

Conflicting evidence presented an issue of fact as to whether a patient discovered the existence of a doctor's alleged malpractice at a time far enough removed from the allegedly negligent act to prevent the statute of limitations from barring her suit, the Supreme Court of Michigan ruled recently. A summary judgment in favor of the doctor was reversed, and the case was remanded for a trial on the merits.

The doctor had removed the patient's gallbladder in 1949, but the patient suffered distress subsequent to the operation. She continued consulting the doctor for a period of about five years. She then consulted several other physicians over a period of twelve years. The last of these doctors discovered that, in the operation, the patient's cystic duct had not been removed. The duct was removed by this latter doctor in June, 1965. Seven months later, the patient filed suit against the doctor who operated in 1949, alleging negligence resulting in injury and suffering.

The patient testified that the question of her gallbladder surgery arose during consultations with all subsequent physicians. She stated that each of them told her that either her gallbladder or the cystic duct thereto remained within her and should be removed. However, some of these same doctors stated that the patient's gallbladder and/or cystic duct was never discussed. The doctor who took an X-ray film of the patient stated that the cystic duct failed to show on the film.

Under the circumstances, the court ruled that the conflicting nature of the testimony warranted a full trial on the merits.— *Winfrey* v. *Farhat,* 170 N.W.2d 34 (Mich., Sept. 24, 1969)

from Vol. 20, No. 4

American Medical Association
Continuing
Medical Education
AWARD

Michigan physicians have received a brochure titled "The Physician's Recognition Award" — a detailing of information regarding the continuing education award program which was established at the AMA Clinical Convention in December, 1968. The 1969 House of Delegates, in their October annual meeting, endorsed this program and recommended that each member strive for the award. Application for the award is voluntary and any physician in any field of medicine may apply to the AMA.

Painful
night leg
cramps...

unwelcome bedfellow for any patient–
including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

Treating vaginitis
is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—

recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]

recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.
References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Taday's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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The concert was just underway,
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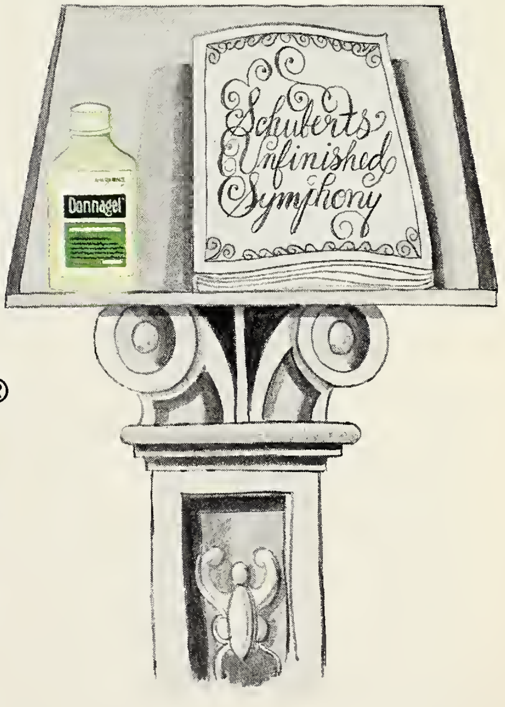

fluid ounce contains: Kaolin, 6 Gm.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 37 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; um benzoate (preservative), 60 mg.; Alcohol, 3.8%.

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Alcohol, 1.4%

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Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●		●
Antihistamine			●		
Long-Acting (6-8 hours)		●			●
Nasal, Sinus Decongestant				●	
Non-narcotic	●	●		●	●

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editorial viewpoints

MDPAC Urges Action During Election Year

BY DONATO F. SARAPO, M.D.
MDPAC CHAIRMAN

Making laws is one of this nation's major activities. It keeps Congress busy for nearly 11 months out of 12 these days. Fifty state legislatures add thousands of laws more each year. Cities contribute a flood of ordinances to the total. The regulatory agencies crank out regulations in awesome numbers.

With the effect this entire process has on a business, an industry, a profession, a group of people, or the individual taxpaying citizen who must conform to the rulings of the legislative majority, it would seem logical to expect breathless attention to all these goings-on from every person of voting age in the United States.

But as all of us know, it doesn't work out that way. Not one person in five is a political activist in the sense that he works for the political party of his choice, supports it financially to the degree that he is able, or turns a hand to the necessary work of helping a candidate win. Until recent years, business, industry and the professions did little more than lobby.

This attitude is changing. Clearly, a loner in politics accomplishes little more than the casting of his single vote, important though that is. Just as clearly, a group of like-minded individuals can multiply their political effectiveness. Nothing prevents separate political groups from forming, on the basis of a shared point of view, and then working for a particular candidate as an auxiliary to his party apparatus during a three or four month campaign.

THE NEW LOOK in candidate support committees is different. They now function as parts of a permanent organization tied to neither party. They are candidate oriented, but work for a selected candidate only during his campaign. They then sever the relationship until the next time the office is being contested and may, if they choose, decide at that time based upon the candidate's record, to support someone else.

These political hybrids are the new political action committees, of which Michigan Doctors Political Action Committee is one, MDPAC is now being organized to field at least one candidate support committee in each congressional district. These PAC Committees are not only here to stay but with other professional and business groups simularly organized, will constitute a force of growing power.

Autonomous political action committees like MDPAC are now operating in each of the 50 states as well as in the District of Columbia, with members belonging both to their state and national political action committees.

SELECTED CANDIDATES are usually recommended by PAC members at the local level on the basis of political principles, chance to win, need for help, and several other factors. The MDPAC members within each congressional district are urged to form a candidate support committee, raise money, and provide volunteer services for the candidates chosen.

If additional financial help is needed, the district candidate support committee applies to the State PAC. Political realism governs that decision. It must be noted here that neither the AMA or MSMS can by law collect or spend money on political candidates. Only MDPAC and The American Medical Political Action Committee (AMPAC) can lawfully raise or dispense political funds. This fact should be made known to more MSMS members.

Recognizing that able, intelligent candidates are to be found within the ranks of both political parties, MDPAC and AMPAC are resolutely bipartisan.

AMPAC is involved primarily in races for the House, but occasionally commits itself to a campaign for the U.S. Senate.

The Michigan Doctors Political Action Committee is oriented to key congressional contests, but also involves itself in campaigns for the state legislatures as well as other selective educational and judicial posts.

AMPAC WAS FORMED with the American Medical Association's official blessing as a voluntary, non-profit, unincorporated organization whose purpose it was to help its members participate effectively in public affairs; further their political knowledge; and develop the means for concerted political action.

At the national level, AMPAC seeks to provide coordination, liaison and political training for its members. In terms of this training, a variety of political education programs is made available for the use by MDPAC members. Courses in precinct action, films on politics, pamphlets on how to form political opinion, a membership periodical, exhibits; these are some of the materials AMPAC produces and disseminates. In essence, this sort of political education is comparable to the programming done by many of the public affairs departments of the nation's large corporations. Write MDPAC, Box 169, East Lansing for this material.

You may ask, does this over-all approach work? It does indeed. AMPAC is now second only to labor in the total of its dollar support to congressional candidates. And AMPAC's files are filled with testimonials from political candidates who believe that the margin between their defeat and victory at the polls was provided by the combined effort of physicians and their wives.

In these troubled days, Congress is called upon to consider a plethora of bills involving the nation's health (there were more than 1,500 of them introduced in the 91st Congress). Medicine clearly has a gigantic stake in the election of intelligent men and women who will at least listen to both sides of an argument before they make up their minds.

MEDICINE'S PAC MOVEMENT both at the national and state levels are helping to assure the election and re-election of such people, recognizing that legislative arguments minus candidate support often equal futility squared.

The MDPAC board is currently assessing the voting record of all legislators and will financially support on a bipartisan basis over 50 candidates for the 1970 legislature. Several members of the Michigan delegation to the Congress have already been recipients of our favor. Others in critical fields will soon. Much more help is needed particularly through MD activist recruits and their wives to organize local candidate support committees. MDPAC has tripled its membership in four years.

Its effectiveness could develop into a brilliant political success story! We need your help to accomplish, in this 1970 election year, a PAC membership of at least a third of the Michigan doctors of medicine. Our goal is to attain 3,000 members in 1970. You can help —

Doctor, for only twenty-five dollars you can help give your profession a strong right political arm. Sign up (for membership, billing is $25.00) to become a member of both AMPAC and MDPAC. Otherwise mail your check to MDPAC, Box 169, East Lansing, Michigan 48823. Join the team!

Quoted from 1961

Kenneth H. Johnson, M.D., President of MSMS for 1960-61, wrote a president's page in the June issue of the MSMS journal after the dedication of the present MSMS headquarters. In part, he wrote:

"The new headquarters for MSMS is one of the most beautiful buildings you will ever see. Most importantly, it is a very real challenge to every physician in Michigan to realize that he has a destiny with the present and the future. Not only will this building be used by the individual components of the MSMS, but it will be a rallying point for many organizations which have important contributions to make to the health and welfare of the people of this state."

Ten Rules To Avoid Court

A Cleveland attorney has suggested ten rules to help doctors avoid appearing in court as defendants. In the February, 1969, issue of *The Physician's Legal Brief*, R. Crawford Morris, who specializes in defending medical liabilities cases, suggested the following rules:

(1) The physician usually can decline to accept a patient. However, Mr. Morris cautions the physician, that while he has an option to step aside, he must do so before he places himself in a position of abandoning the patient.

(2) Never guarantee a cure. The physician who promises a cure or uses language intimating

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- Medico-Legal counsel.
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such promise can be sued, not only for negligence, but for breach of contract as well, if the promised results do not materialize.

(3) Watch the time factor, especially if there has been an unfortunate result. This rule relates to the statute of limitations as they vary in each state.

(4) Keep up with the advances in medicine. A physician will be judged by what is considered good medical care at the time he renders treatment.

(5) Do not use unnecessary experimental procedures. Mr. Morris advises that if a physician finds such procedures necessary, he should announce it frankly as such and obtain a written informed consent for the procedure.

(6) Make a simple, reasonable disclosure of the risks involved, unless there is a therapeutic reason for not telling the patient. In these instances it is advisable to tell the patient's relatives, but obtain an informed consent from the patient for everything done.

(7) Keep good records. Should a trial ensue, records are important because they always are admissible as evidence, while witnesses to an event may not be available.

(8) Cooperate with the medical profession. This rule is laid down in an effort to caution physicians against loose talk which can promote law suits.

(9) Do not be hesitant about consultation. Mr. Morris cited a case he tried and won because there were numerous consultations in an effort to make a correct diagnosis. The diagnosis was incorrect, but the best men in town were called in for consultations which refuted a claim that the physician's conduct was negligent.

(10) Maintain good public relations. Mr. Morris noted that a physician should "be as careful with your tongue as you are with your scalpel." Incidents, in which patients overhear comments about their condition, can constitute inferior medical practice, as well as poor public relations, and are apt to promote law suits.

"Try Being A Leader," Urges Auxiliary Officer

BY MRS. JAMES FERGUSON
FIRST VICE PRESIDENT
WOMAN'S AUXILIARY TO MSMS

"Accent on Youth — Accent on You" — this is the 1970 theme of the Woman's Auxiliary to the American Medical Association.

Youth means the wee small baby — and that same baby when he or she reaches the age when parents sometimes seem unable to communicate — the teen age. There are 70 million youth under the age of 18 in America today. We must restore trust; where there is trust there is communication.

The You part of the theme means community involvement; try being a leader with a "let's go" attitude.

Wisconsin State Medical Society members backed their State Auxiliary for the second year with a program on drugs produced over free TV. It was more than a success — only woman power was needed. The Blue Shield at the same time underwrote distribution of "The Drug Turn On," a pamphlet given to all high school students. It is unfortunate that we are not able to do something of this type in Michigan.

A strong family unit is a most important factor, as most doctors and clergy will agree. Parent Education could be the start in the many things to be done. Other goals might be sex education with the help of the medical societies in lower grades as well as in high school, greater public awareness of the VD rates in teenagers, the child abuse law . . . does Michigan have an immunity clause?

We must help educate the young, from college-age down to the little ones, on the physical and emotional pitfalls that are a part of not knowing about the abuse of drugs, alcohol and narcotics. We are all a part of our community and hopefully . . medically . . and as doctors' wives . . we can make it a better one.

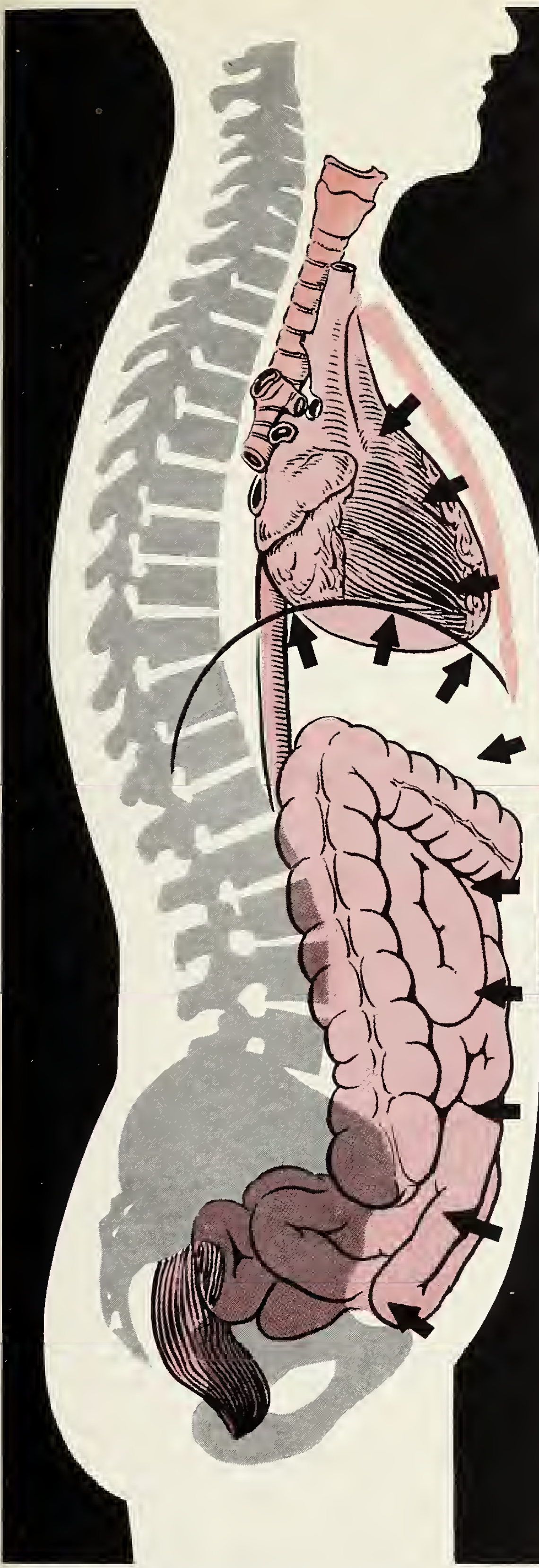
Mental Health Programs Oversold

(The following article is reprinted, with permission, from the November-December issue of THE CIRCULAR, a bi-monthly newsletter printed by the Oakland County Community Mental Health Services Board. Doctor Romero is director of the board.)

Community mental health programs have been oversold, the director of one of them contends. This has left legislators with unrealistic expectations and the programs themselves with a lot of false promises to back out of.

Dr. Lino Romero, director of the Oakland County Community Mental Health Services Board, expressed this view before 60 persons attending a Nov. 10 meeting for public officials. The meeting was sponsored by the Oakland County chapter of the Michigan Society for Mental Health.

(Continued on Page 172)



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Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice*, 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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Expectations must be brought back into line with reality, Dr. Romero said.

"If we become honest about confessing our ignorance, we'll be on the right track. If we have failed, we have to admit it. We can't just holler for more money."

On the other hand, Dr. Romero said, if community mental health programs are really doing something worthwhile, they must be prepared to document it. "We may even find out, in the process, that it doesn't make any difference whether there's an Oakland County community mental health program or not!"

In looking at the total picture, Dr. Romero said his own view is that "we simply are not doing the job we should be doing in community mental health."

One reason for this, he said, is that "we professionals apply the concepts of yesterday to the problems of today and even tomorrow. That doesn't work, and we fail miserably."

He noted that the mental health field lacks a solid foundation of scientific achievement from which to proceed — a situation which makes true prevention impossible and effective treatment difficult.

"We don't even agree on exactly what mental illness *is* though we know, of course, that it exists," Dr. Romero said, "We can only describe behavior. And if we cannot understand and cannot tolerate that behavior, we call it illness."

He said that too often, "when we cannot tolerate behavior, we seek merely to control it." While Dr. Romero admitted the necessity for restraining dangerous mentally ill persons, he said that security precautions should be recognized for what they are and not passed off as "treatment."

Dr. Romero said the major thrust should be *not* on control of deviant behavior — a holdover from the witch hunts of the 15th Century — but on seeking new knowledge and understanding.

He emphasized the need for more basic research into the biological causes of mental illness, along with studies of the part played by environment and social change. Until such knowledge is available, he said, "pleading for more money to build another hospital won't really solve anything."

Dr. Romero sharply criticized mental health professionals, government organizations and citizen groups for "educating" the public with guesswork often disguised as fact. He quoted conflicting figures suggesting that anywhere from 10 percent to 80 percent of the nation's people need mental health care.

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Stephen C. Mason, M.D.
Philip M. Margolis, M.D.
Hubert Miller, M.D.

* 1904 - 1967

The Case For Peer Review

A Sociological, Paleontological Fable

BY DOCTOR AESOP

"It was fear that first made the gods." People were afraid of the earth's forces — wind, sky, oceans, rivers, trees — and religion evolved as the propitiatory worship of these forces. Only when priests used these fears to support morality did religion become a vital moral force standing above the power of the state.

But as education spread, the moral codes lost their aura and force; their human origin was revealed, and divine surveillance and sanctions were removed.

In a fashion not unlike the growth of religious spirit among people, there grew a fraternal spirit among physicians. It was fear of savage force and religion that first made it desirable for doctors to band together in professional unity.

They defied the lay power of the state and the spiritual strength of the religious world. Their own high ethics and their claims to standards of knowledge gave them mystical strength.

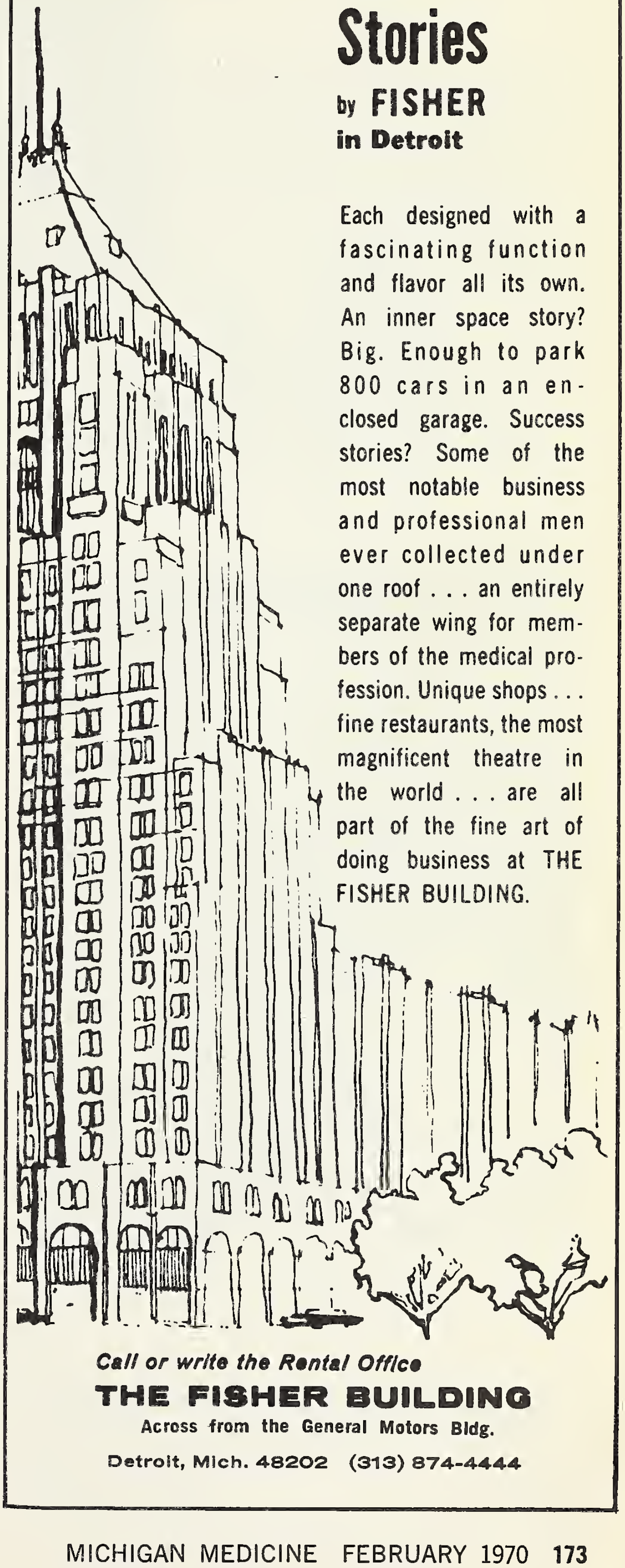
But times change, and as education increased, science seemingly became more important to the physicians than ethics, and the latter lost its force. As the group surveillance and sanctions weakened, the professional societies decayed and the state found it necessary to intervene, apparently in behalf of the people — to protect them from the physician's knowledge — power that was now exposed as being bereft of peer control.

The state did so with alacrity, finding it popular to not only pose as the protector of the weak, but via its economic power, to appear to be the purveyor of physician's services.

Once again the physicians sought to band together, this time in fear of the state, but in so doing they found their purposes suspect — outside the law.

And the profession died as an entity.

Perhaps it will rise again as one or more of the most resilient doctors raise a new flag. The tragedy is that the profession needn't have died had its members recognized the popular strength that resided in the ethics upon which its unity was initially founded. Adherence to ethics is the *sine qua non* of professional life. (*H.W.B.*)



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The MSMS Council In Session

MEDICAID PAYMENTS, umbrella insurance and the MSMS budget were topics of discussion at a recent meeting of The MSMS Council. In close concentration are these MSMS leaders, from left, Ralph R. Cooper, M.D., Detroit, vice chairman of The Council; Hugh W. Brenneman, MSMS executive director; Ross V. Taylor, M.D., Council chairman; Robert J. Mason, M.D., MSMS president, and Warren F. Tryloff, MSMS associate executive director.

DOCTOR TAYLOR, standing, confers with MSMS Associate Executive Director Mr. Tryloff.

COUNCIL DELIBERATIONS at the recent meeting included the setting of future MSMS meeting dates, the establishing of an ad hoc committee and the approving of guidelines for inviting guests to Council meetings. Full attention to the details is given by Kenneth H. Johnson, M.D., Lansing, right, secretary of The Council, and Mrs. Vada Davis, secretary to Mr. Tryloff.

NEW COUNCILOR Ernest P. Griffin, M.D., Flint, left, listens carefully at his first regular Council meeting following his election at the MSMS Annual Session. On hand to lend counsel is Clyde T. Hardwick, Detroit, right, MSMS economic consultant. (Photo at right)

THE LARGE BOAT-SHAPED TABLE in the Board Room at MSMS Headquarters is surrounded by MSMS staff members and councilors from 19 districts around Michigan, who ponder and make decisions on the medical issues of the day.

COUNCIL MEMBERS J. Robert Franck, Jr., M.D., Wakefield, left, and Vernon V. Bass, M.D., Saginaw, vice speaker of the MSMS House of Delegates, give full attention to the meeting topics, which included revisions of the Relative Value Study, an Annual Session report and implementation of a crash injury study.

AMONG NEWEST members of the MSMS Council is Adam C. McClay, M.D., Traverse City, left, who is seated beside new MSMS President-Elect Harold H. Hiscock, M.D., Flint.

TAKING NOTES during discussion at The Council's meeting is Sidney Adler, M.D., Detroit, left, new chairman of The Council's Finance Committee, and Speaker of the MSMS House of Delegates, James B. Blodgett, M.D.

Not present when the photographer was at the Nov. 5 meeting of The MSMS Council, and therefore not in the pictures are Councilors Brooker L. Masters, M.D., Fremont, William A. LeMire, Sr., M.D., Escanaba, and James J. Lightbody, M.D., Detroit.

MSMS COUNCILORS Robert C. Prophater, M.D., Bay City, center, and Robert M. Leitch, M.D., Union City, right, are attending their first regular meeting of The Council following their election to the medical society's board of directors at the Annual Session Sept. 28-Oct. 2. Milton R. Weed, M.D., of Grosse Pointe Park, is at left.

CONTINUING IMPROVEMENTS to **Michigan Medicine** were acted upon at the recent meeting, to the special interest of John W. Moses, M.D., left, the journal's scientific editor. A First District councilman, Robert K. Whiteley, M.D., is at right.

DEEPLY ENGROSSED in materials which help them make decisions on matters before The Council are, from left, Harold F. Falls, M.D., Ann Arbor, and Sydney Scher, M.D., Mt. Clemens.

PONDERING MATERIALS relative to The Council's business is John J. Coury, M.D., Port Huron, right, while Don W. McLean, M.D., Detroit, listens to the debate.

Doctor, after all we've been through together...

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acne
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anthrax
bacillary dysentery
bartonellosis
bronchitis
bronchopulmonary infection
brucellosis
chancroid
diphtheria
endocarditis
genitourinary infections
gonorrhea
granuloma inguinale
listeriosis
lymphogranuloma
mixed bacterial infection
osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
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Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

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in memoriam

Harry Arnkoff, M.D.
Pontiac

Harry Arnkoff, M.D., a member of the Oakland County Mental Health Board and a past president of the Oakland County Medical Society, died Nov. 18 at the age of 56.

Doctor Arnkoff was chief of staff at St. Joseph Mercy Hospital, Pontiac, in 1960 and was graduated from the University of Michigan Medical School. He was a member of the American Psychiatry Association and was on the board of governors of the Jewish Welfare Federation. He was affiliated with Pontiac State, Pontiac General and St. Joseph Mercy Hospitals in Pontiac.

Effie E. Arnold, M.D.
Detroit

Effie E. Arnold, M.D., a physician with the Total Action Against Poverty Program, (TAP) from 1957 to 1967, died Nov. 19 at the age of 82.

Doctor Arnold was a graduate of the University of Michigan School of Medicine and had a life certificate to teach. She served 45 years in the social hygiene clinic at Receiving Bureau of Detroit General Hospital, retiring there in 1957. She was formerly on the board of directors of the Michigan Humane Society.

Lambertus E. Beeuwkes, M.D.
Dearborn

Lambertus Eugene Beeuwkes, M.D., Dearborn physician for more than 30 years, died Nov. 22 at the age of 66.

Doctor Beeuwkes had been a member of the staffs of Crittenton and Mount Carmel Mercy Hospitals and served at Harper Hospital at the time of his death. He was a member of the Detroit Society of Gastroenterology, the American College of Gastroenterology, the Detroit Diabetic and American Diabetic Associations.

A specialist in internal medicine, Doctor Beeuwkes was graduated from Rush Medical College.

Allen E. Brunson, M.D.
Sturgis

Allen Eugene Brunson, M.D., Sturgis general practitioner, died Dec. 14 at the age of 60.

Doctor Brunson, a graduate of the University of Michigan Medical School, was affiliated with Sturgis Memorial Hospital. He was a past president of the St. Joseph County Medical Society.

Ray E. deSpelder, M.D.
Detroit

Ray E. deSpelder, M.D., a Detroit general practitioner since 1921, died Dec. 5 at the age of 75.

Doctor deSpelder had also been on the staff of Grace Hospital, Detroit, since 1921 and was a graduate of the University of Michigan Medical School.

Norman D. Henderson, M.D.
East Lansing

Norman D. Henderson, M.D., East Lansing general practitioner for 10 years, died Dec. 10 at the age of 51.

Doctor Henderson was a graduate of Wayne State University and was a member of the American Academy of General Practice. He was a former chairman of the MSMS Liaison Committee with Residents, Interns and Medical Students.

Leo Hart Holm, M.D.
Muskegon

Leo Hart Holm, M.D., Muskegon anesthesiologist, died Dec. 26 at the age of 43.

Doctor Holm was affiliated with Hackley Hospital and Mercy Hospital, both of Muskegon, and was graduated from the College of Medical Evangelists of Loma Linda University. He was a member of the American Society of Anesthesiologists and the International Anesthesia Research Society.

Clarence G. Leslie, M.D.
Detroit

Clarence G. Leslie, M.D., Detroit general practitioner, died Dec. 19 at the age of 56.

Doctor Leslie was graduated from Howard University School of Medicine and was affiliated with Burton Mercy and Boulevard General Hospitals in Detroit.

Robert W. McClure, M.D.
Detroit

Robert W. McClure, M.D., Detroit obstetrician and gynecologist for 23 years, died Dec. 29 at the age of 60.

Doctor McClure was on the staffs of Harper and Hutzel Hospitals, Detroit, and served as an instructor of clinical obstetrics and gynecology at Wayne State University School of Medicine from 1947 to 1968, when he retired.

Doctor McClure was graduated from Wayne State University College of Medicine and was a fellow in the American College of Surgeons and the American College of Obstetrics and Gynecology.

Edward T. Roth, M.D.
Detroit

Edward Theodore Roth, M.D., Detroit physician for 48 years, died Dec. 14 at the age of 77.

Doctor Roth was a life member of the Wayne County Medical Society and was a member of the staff of Grace Hospital, Detroit. A general practitioner, he was graduated from the Detroit College of Medicine and Surgery.

Edward L. Sager, M.D.
Detroit

Edward Lee Sager, M.D., Detroit general practitioner for 44 years, died Dec. 13 at the age of 74.

Doctor Sager was affiliated with Saratoga General Hospital in Detroit and was a graduate of Ohio State University School of Medicine.

John F. Sander, M.D.
Lansing

John F. Sander, M.D., Lansing pediatrician for over 40 years, died Dec. 3 at the age of 71.

Doctor Sander was a past president and life member of the Ingham County Medical Society and at the time of his death was director of the Pediatric Outpatient Clinic at E. W. Sparrow Hospital, Lansing.

He was chief of pediatrics at Sparrow Hospital from 1928 to 1959 and was also on the consulting senior staff of St. Lawrence Hospital, Lansing; an assistant clinical professor in the Department of Human Development, College of Human Medicine, Michigan State University, and had been on the faculties of Harvard Medical School and the University of Michigan Medical School. He was a graduate of the University of Michigan Medical School.

L. Paul Sonda, Sr., M.D.
Detroit

L. Paul Sonda, Sr., M.D., former chief of staff of Southfield's Providence Hospital, died Nov. 24 at the age of 73.

Doctor Sonda was a fellow of the American Academy of Pediatrics and was certified by the American Board of Pediatrics. He was graduated from the Jefferson Medical College, Philadelphia, and was a member of the Detroit Pediatric Society.

Roy D. Tupper, M.D.
Detroit

Roy D. Tupper, M.D., a Detroit physician for 52 years, died Dec. 9 at the age of 77.

A former chief of staff at Mt. Carmel Mercy Hospital, Doctor Tupper was a graduate of the Detroit College of Medicine and Surgery. He belonged to the American College of Cardiology. He was a specialist in internal medicine.

Doctor Tupper had served as health officer for Redford Township, Wayne County, for 14 years and was a member of the former MSMS Committee on Rheumatic Fever Control.

William R. Vis, M.D.
Grand Rapids

William R. Vis, M.D., long-time Grand Rapids internist, died Nov. 30 at the age of 83.

Doctor Vis was author of a historical novel, "Saddlebag Doctor," describing medical practices in Grand Rapids in the 1830's, and was preparing another book, "Men, Women and the Miracle of Medicine," at the time of his death.

Doctor Vis was graduated from the University of Michigan Medical School and was past president of the Kent County Medical Society. He served as first director of Grand Rapids Sunshine Hospital and served on the staffs of St. Mary's, Blodgett Memorial and Butterworth Hospitals in Grand Rapids. He was an ordained elder in Westminster Presbyterian Church, Grand Rapids, and a fellow of the American College of Physicians.

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FOR SALE — Mattern X-ray machine, 100 milliamp., Model Med.-100 DF, Rotating anode. Lead shield and accessory equipment; approved by Michigan Dept. of Health. Terms open. Reply: Box #2, 120 West Saginaw Street, East Lansing, Michigan 48823.

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GENERAL SURGEON, General Practitioner, Internist and OB-GYN needed for established multi-specialty group in Detroit. Excellent professional relationship. Reply: Box #3, 120 West Saginaw Street, East Lansing, Michigan 48823.

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Community of 10,000 in Southern Michigan needs GP's and Pediatricians. Fully accredited Hospital with ICCU. Ideal family community located 30 minutes from Ann Arbor, 60 minutes from Detroit and 45 minutes from Toledo. Excellent schools and recreational facilities. Contact Larry T. Burch, M.D., 10 Cairns Street, Tecumseh, Michigan 49286.

Index to Advertisers

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Arch Laboratories 150
Arnar-Stone Laboratories 147
Brown Pharmaceuticals 148
Burroughs Wellcome & Co. 141
Campbell Soup Co. 133
Chicago Medical Society 146
Classified Ads 180, 181
Fisher Bldg., The 173
Geigy Pharmaceuticals 142, 143
Hoechst Pharmaceuticals 171
Hynson, Westcott & Dunning 97
Ingram, G.A., Company 132
Lederle Laboratories 102, 151, 177
Lilly, Eli & Co. 106
Mallard, Inc. 153, 154
Mead Johnson Laboratories 130, 131, 138, 139, 160, 161
Medical Protective Co. 149
Mercywood Hospital 172
National Drug Co. . . . . Cover II, 163, 164
Parke-Davis & Co. 157, 158
Plainwell Sanitarium 169
Poythress, Wm. P. 155
Robins, A.H. & Co. 127, 136, 156, 165, 166, 167
Roche Laboratories . . . . Cover IV
Sandoz Pharmaceuticals 144
Searle, G.D. & Co. 134, 135
Smith, Kline & French Labs . . . . Cover III
Stratton, Ben P. 101

noted and quoted

BY HERB AUER, EXECUTIVE EDITOR

A recent issue of the *Morgan Guaranty Survey* provides some interesting statistics about population patterns. Following are a few:

— There are fewer children under age five today than there have been for many years. Elementary school attendance will drop about 5 million during the 1970's to 32.4 million pupils.

— College enrollments will continue to climb during the 1970's from 7 million today to more than 11 million in 1980.

— By 1980, there will be 74 million high school graduates — 18 million more than at the beginning of the 70's.

— The number of college graduates will climb from 12.5 million to 18 million during the decade of 1970-1980.

* * *

The MSMS contention that peer review committees are essential is supported by Louis A. Orsini, director of the Health Insurance Council, New York City. Mr. Orsini recently declared that "The peer review mechanism for physician review of fees and services offers the best vehicle for the medical profession to respond to public demand for effective controls over the health care system." He added that "Peer review is a tool through which the judgment of the medical profession can constructively influence the pricing pattern which will control the method of reimbursement for physicians' services and the delivery of quality medical care." The work of peer review committees, he believes, "can demonstrate to the public that fee-for-service medicine coupled with peer review provides quality care at reasonable cost."

* * *

A recent issue of the *Maryland State Medical Journal* carried some figures about annual wages and hourly pay schedules:

Carpenters,
$4.82 per hour, union rate
Electricians,
$5.45 per hour, union rate
Plumbers,
$5.21 per hour, union rate
Linotype Operators,
$4.50 per hour, union rate
Bricklayers,
$5.80 per hour, union rate

According to the latest *Medical Economics Survey*, the average physician works anywhere from 60, 70 to 80 hours per week.

	ANNUAL WAGE		
	40 hrs.	60 hrs.	80 hrs.
Carpenters	$10,025	$17,544	$25,063
Electricians	11,336	19,843	28,350
Plumbers	10,837	18,970	27,103
Lino. Oprs.	9,750	16,770	23,790
Bricklayers	11,232	19,656	28,080

* * *

Michigan's Acting Superintendent of Public Instruction, John Porter, in his first public major address set forth four major goals for education in Michigan. The four goals were: (1) To establish area vocational education centers utilizing existing facilities where appropriate to provide specific skills to the youth and to measure whether this approach will have an impact; (2) to try to balance out the funds going to schools and to determine if the additional aid is having a positive impact on equalizing student achievement; (3) to sell the idea of more education for the disadvantaged, and (4) to urge a change in the priority system so students can be measured and to take corrective steps where necessary.

* * *

"We are coming to a time when everybody in the United States will be covered by some form of insurance for his medical care. Under the American system the patient must be boss over himself and his money, and the government can insure that money will be available for his medical care," declared Morris Fishbein, former JAMA editor, in a recent speech before the Detroit Sinai Hospital staff.

"But the government should not pick your doctor, pick your hospital, tell your doctor what to do for you or how long he should work for you," he said.

Doctor Fishbein's visit was sponsored by the editorial staff of the *Sinai Bulletin*, the hospital's quarterly medical staff publication.

* * *

Louise M. Gloeckner, M.D., of Philadelphia, vice president of the AMA, believes "sex education should be taught to members of the PTA."

"Go ahead with the classroom education but teach the PTA too. Then the parents would know just as much about the subject as their children."

* * *

Illness among the middle-aged people (45-64) costs Britain about $2.4 billion a year, more than any other age group . . .

michigan medicine

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Special Issue: The Himler Report
February 1970, Volume 69, Number 4
Michigan State Medical Society

michigan medicine

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MSMS Invites Responses To The Himler Report: Read, Study Condensation and Minority Report

The AMA Committee on Planning and Development has presented to the AMA Board of Trustees a monumental survey of health practices in the United States. The so-called Himler Report represents a detailed evaluation of our present system and projections for future goals for the delivery of health services.

The Council of MSMS feels this report to be of such value that it devotes this entire issue of MICHIGAN MEDICINE to a condensation of The Himler Report produced by John W. Moses, M.D., MSMS Scientific Editor. We urge every member to study this report. The future practice of medicine may well depend on how these observations and recommendations are implemented by the medical profession and the public.

—Brooker L. Masters, M.D., Chairman
MSMS Publication Committee

At the House of Delegates Meeting of the 1969 Clinical Convention of the American Medical Association held in December, 1969, a report of tremendous importance to the members of the American Medical Association was presented. This report should have considerable impact upon the A.M.A.'s future activities and the future of the A.M.A. as an organization: Report I of the Board of Trustees, including the report of the Committee on Planning and Development (The Himler Report) and the Minority Report (John H. Budd, M.D.). This report and the recommendations of the Reference Committee and its considerations of this report should have serious consideration by all members of the American Medical Association.

Recently, the Board of Trustees of the American Medical Association established a Committee on Planning and Development. This Committee was chaired by George Himler, M.D., and was given the following charges: "1) To study and make recommendations concerning the long range objectives of the Association and the resources, programs and organizational structure by which the Association attempts to reach them. 2) To serve as a focal point for the planning activities throughout the Association. 3) To study, or cause to be studied, medicine in the environment in which the Association must function, and transmit the conclusion of these studies, in the form of recommendations, to the Board of Trustees for distribution to appropriate decision making centers throughout the Association, particularly the House of Delegates."

The Committee presented its report to the 1969 Clinical Convention of the American Medical Association House of Delegates, with 18 groups of recommendations totalling 57 in number. At the same meeting, a minority report was submitted offering 19 recommendations and suggesting this as only a partial list. The "Himler Report" and Minority Report were presented to the Reference Committee at this meeting.

Prior to the Reference Committee meeting, the delegates to the A.M.A. had ample opportunity to review this 60-page report and 6-page minority report. Needless to say, there was considerable consternation among the delegates as to the outcome and recommendations of both the majority and minority reports. The Reference Committee meeting was probably the largest attended meeting of any Reference Committee in A.M.A. history.

The Reference Committee came up with three recommendations. The first was to the effect that it be the policy of the House of Delegates that a permanent Committee on Long Range Planning and Development be appointed. This was passed. Recommendation 2 in essence set up an Ad Hoc Committee on Long Range Planning and Development to receive both the Himler Report and the Minority Report and to study and make recommendations concerning the structuring of and charge of the permanent Committee on Long Range Planning and Development, and to report any recommendations to the House of Delegates at the Annual Convention in 1970. This likewise was passed.

Recommendation 3 reads as follows: "Your Reference Committee believes this House of Delegates can better act on the specific recommendations of the Himler Report and the Minority Report on the benefit of the individual resolutions to be submitted by the component and constituent state associations or societies. It, therefore, further recommends that these two reports be transmitted to the component state societies for such specific action by the Governing Bodies as they deem warranted, it being understood that the resolutions so generated and all recommendations in the Reports of the Committee on Planning and Development will be considered by the appropriate Reference Committees at the Annual Convention of 1970." This likewise passed.

It was felt by many people in the A.M.A. House of Delegates that the Himler Report and the Minority Report (Budd Report) were probably two of the most important documents to come before the A.M.A. House of Delegates since possibly the Flexner Report of the early decades. It was felt also, by many of the Delegates that the Himler Report generated a great deal of controversy and that no definite action could be taken at the session in December, 1969, on such short notice. It was also feared by many that the Report could be shelved and no definitive action could be forthcoming over a long period of time. The Michigan Delegation, chaired by Donald N. Sweeny, Jr., M.D., was active in the discussion at the Reference Committee, and was active in the recommendations that the Reference Committee accepted.

It was felt that Recommendation #3 was of great import and could be a means of actively inaugurating such recommendations in the Himler Report as were considered of prime importance by the general membership of the American Medical Association. Since Recommendation 3 gives a means, or method of each State presenting such resolutions to the next session of the A.M.A. as they feel expedient, it, therefore, appears that these recommendations should become general knowledge to the membership of the Society as a whole. Although this report is rather lengthy and contains a great deal of material which should be deeply studied, we feel it should be presented here for full membership perusal, study and recommendations.

We hope the membership of the Society as a whole will seriously consider the recommendations of the Himler Report and the recommendations of the Budd Report and make their feelings known to the Council of the Michigan State Medical Society and to the Delegates of the Michigan State Medical Society to the American Medical Association.

We are, therefore, presenting the report's recommendations as outlined, and suggest that, should anyone desire further information or background material, they write to the Executive Director of the State Medical Society, and he will attempt to make this material available to the membership.

THE HIMLER REPORT

The Report suggested two basic considerations: First, that the A.M.A. adopt the following as a statement of the primary purpose and responsibility of the Association to the medical profession: "To endeavor, by all appropriate means, to make health services of high quality available to all individuals in a dignified and acceptable manner, regardless of their social class, ethnic origin, ability to pay for services, or the source of the payment."

Further, that while the A.M.A. must be prepared to accept some circumscription of the traditional privileges and freedoms of physicians, the following policy be adopted: "That the American Medical Association recognize the need for new and improved methods of delivering health services, that it encourage and participate in efforts to develop them, and that in the interest of attracting the most highly qualified candidates in the field of medicine, it simultaneously make every effort to maintain and create incentives in medical practice. Among these incentives are minimal regimentation, a multiplicity of practice options, and freedom of choice for both physicians and patients."

The following are the recommendations of the Himler Report:

BASIC CONSIDERATIONS

"I. That the A.M.A. officially adopt the following World Health Organization definition of health: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'

"II. That the A.M.A. adopt an active role and take the initiative in developing all plans and programs for health care in all their ramifications and that it encourage and assist the state and county medical societies to do the same at their respective levels.

EVALUATION OF CURRENT TRENDS

"III. 1. That an appropriate committee or division of the Association secure data from all the state medical societies on the adequacy of health services and the manner in which they are being prepared in their rural and underprivileged areas, and the practice mechanisms, if any, that are being considered or developed, to correct existing deficiencies. Based on this information, the same Committee should devise delivery systems consistent with the Association's principles and incentives for physicians to settle in medically deprived localities.

"2. That the Association, in conjunction with the state and county medical societies, establish a service of consultation and assistance for such physicians to facilitate the planning and financing of their projects.

"3. That, in those instances in which the physicians cannot be found to develop health care facilities with the capability of providing needed services, the A.M.A. urge, encourage, and assist the state and local medical societies to do so on an operational basis.

"4. That the Association study the possibility of establishing a corporation for this purpose, with subsidiary corporations on state and local levels. All such corporations should be legally empowered to receive payments for services rendered and would apply surplus income over expenditures to activities designed to improve health care in their areas, both quantitatively and qualitatively.

"5. That the A.M.A. and the constituent and component medical societies seek the active involvement of medical centers and voluntary hospitals in health service projects for the medically underprivileged.

SHORTAGES OF HEALTH PERSONNEL BY PROFESSION AND SPECIALTY

"IV. 1. That the A.M.A., through its Council on Health Manpower, in conjunction with other professional, educational and lay associations, continue to explore and develop expedients to overcome health manpower shortages.

"2. That the Association, in its future declarations and activities directed toward the alleviation of shortages in health services and personnel, underscore the fact that these shortages are *not* due merely to an insufficient number of health professionals across the board, and emphasize that maldistribution of practitioners geographically, by profession, and by specialty, is an equally important factor in depriving communities of an adequate supply and spectrum of health services.

"3. That the Association publicize the reasons for the maldistribution, as outlined in this section, and stress that the *voluntary* correction of these deficiencies requires public cooperation and community action in addition to the measures taken by the health professions.

"V. 1. That an appropriate committee of the A.M.A. immediately begin to formulate a policy on doctor's assistants, particularly with regard to their responsibilities, limitations on their practice, and supervision of their services by qualified physicians.

"2. That the A.M.A. reaffirm the principle that the basic responsibility for the care and welfare of patients lies with their physicians of record, and that responsibility cannot and should not be delegated.

"3. That the Association's Law Division assist the state medical societies in identifying and avoiding any legal hazards that may accompany the employment of doctor's assistants.

DELIVERY SYSTEMS FOR HEALTH CARE

"VI. 1. That the Association take no public position for or against private solo practice, private group practice, closed panel group practice, fee for service payment, or pre-payment by capitation.

"2. That an appropriate committee of the A.M.A. be charged with the task of establishing the basic criteria which any proposed system of delivery of health services or mechanism for payment must satisfy to be acceptable.

"3. That the Association, in all public statements, emphasize the concept of differences in education, cultural and economic levels which create problems that may necessitate different systems of delivering medical care for different population groups.

"4. That the state and local medical societies be encouraged and assisted in devising and proposing practice expedients suited to their localities and their problems.

"5. That the Association, in conjunction with the state and county medical societies, establish a consultation and assistance service for physicians or groups of physicians who wish to develop organizations or programs for the rendering of health services.

"6. That the A.M.A. endeavor to be informed of all of the pilot projects that are proposed by other sources, and that it request the Department of H.E.W. to discuss those projects with the Association before they are put into effect.

"7. That the Association seek to insure that the value judgments made by the Department of H.E.W. on plans, programs, pilot projects and payment mechanisms are firmly based on the criteria and standards the A.M.A. has developed for that purpose.

MEDICAL SOCIETY NEGOTIATION IN GOVERNMENT PROGRAMS

"VII. 1. Urge state medical associations to undertake various studies, including surveys of prevailing medical fees.

"2. Develop a uniform methodology for conducting such studies to the end that the data from the various states and localities be comparable.

"3. Serve as a clearing house for the material thus obtained and, after analysis, redistribute the data to the state medical associations with suggestions and conclusions.

"4. Urge the state medical associations to designate negotiators who are qualified to deal energetically with government agencies on all matters pertaining to tax-supported programs. Such individuals or groups should be formally appointed and the government jurisdiction involved should be notified that all negotiations will be conducted by them.

MONITORING OF PROFESSIONAL FEES

"VIII. 1. That the A.M.A. urge state and county medical societies to assume the functions of monitoring fees and containing the costs of health care.

"2. That the Association, in cooperation with the constituent societies, determine what powers the state and local societies require to serve these functions and how these powers can be best obtained.

AUDIT AND POSTGRADUATE STUDY

"IX. 1. Endorse the principle of voluntary, life-long post-graduate study for all physicians and continue and accelerate the development of programs and incentives for such study.

"2. Through the state medical societies, investigate the current status of in-hospital audit methods and make a similar investigation of the state of development of the evaluation of office services.

"3. Encourage and assist the state medical societies and state departments of health and welfare to develop uniform and effective methods of audit for both office and in-hospital services, based on electronic data processing, to the maximum possible extent.

"4. Request the Law Division to clarify the extent to which a physician's responsibility for the privacy of his patients' records will permit him to cooperate in an audit of his office practice.

GOVERNMENT PROGRAMS AND LICENSURE

"X. 1. That the A.M.A. encourage and assist all state medical associations to devise programs for voluntary post-graduate study designed to maintain medical education at an optimum level and to be least disruptive to the provision of medical services.

"2. That the Association obtain information from each state medical society as to whether special requirements have been imposed on physicians who render services to patients under the provision of tax-supported programs and obtain the specifics of what these requirements are.

"3. That, in those states where the health or welfare departments have imposed special requirements on physicians to participate in their programs, the medical society reject those requirements and that, if the need for such regulation can be demonstrated, the state medical society, education department and health department cooperatively develop standards to be incorporated into the education law and enforce on all physicians of that state, thereby eliminating double standards for medical practice and restoring the licensing authority to the proper agency.

PHYSICIAN-HOSPITAL RELATIONSHIPS

"XI. 1. That the Association secure data from state and county medical societies on problems in physician-hospital relationships in their area and the measures, if any, that are being taken to solve them.

"2. That, on the basis of these data, the Association identify the basic principles that apply to staff-hospital relationships and encourage state and county medical societies to do the same.

"3. That the Association in each state and county medical society request its counterpart in the hospital association structure to assist in developing guidelines and urge their member associations and hospitals to implement them.

EFFECTS OF MEDICARE, MEDICAID ON VOLUNTARY HEALTH INSURANCE

"XII. 1. That the Association, through its current liaison with the N.A.B.S.P., seek to obtain continuous and current information on the Medicare Program; that it secure data on the development of additional benefits, new fields of coverage, and minimum standards of benefits and voluntary plans; and that, through the N.A.B.S.P., it stimulate the Blue Shield plans to greater efforts in upgrading their programs.

"2. That a similar liaison committee be developed in conjunction with the Blue Cross National Association for similar purposes.

"3. That the A.M.A. advise state and county medical societies to take similar action at their respective levels and to review their representation on the Boards of Directors of their local Blue Plans to be sure that the representatives are individuals who are currently active in society affairs and familiar with society policies.

"4. That the Association seek a formal and direct channel of communication with the Department of Health, Education and Welfare, with the object of developing its own capacity for modifying existing and new programs when such modification is indicated, rather than relying on the N.A.B.S.P. for this purpose.

HEALTH BILL OF RIGHTS

"XIII. 1. An appropriate committee or division of the Association gather information from the state medical societies on the availability of physicians, ancillary personnel, hospital beds in all categories, laboratories, public health nurses, social service workers, and all other types of health professionals.

"2. The Association promulgate a 'Health Bill of Rights' to identify the services that comprise comprehensive health care.

"3. On the basis of the data obtained from the state medical societies, the Association establish minimum standards for health care and the system of priorities for the provision of services beyond those of minima, thus creating both an immediate and a long range schedule for their attainment.

"4. The 'Bill of Rights,' the data and the standards and priorities receive wide publicity.

SUMMARY OF PROBABLE FUTURE ENVIRONMENT

"XIV. The Committee therefore *recommends*:

(1) That the Association request the state medical societies to submit information on the status of comprehensive areawide planning in their states and the problems that are being encountered.

(2) That this information be analyzed, summarized, and redistributed to the state societies, together with the suggestions made in the preceding paragraphs and a resume, prepared by the Law Division, of the provisions in the law that are pertinent to those suggestions.

CONSIDERATIONS OF STRUCTURAL REORGANIZATION OF THE AMA

"XV. The Committee therefore *recommends*: That the present structure of the association be retained and that it be strengthened by improvements and modifications in its function.

STATE AND COUNTY ORGANIZATION OF RESEARCH DIVISIONS

"XVI. 1. That an immediate survey be conducted of the state medical societies and, through them, of the component county medical societies to determine what arrangements they have made, if any, for the regular collection of data on the socio-economics of health care.

"2. That, on the basis of the information received, the A.M.A. develop tables of organization for research divisions at the state levels and methods of participation of the county societies that are in keeping with their resources. The planning should be developed along lines that are compatible with the concept of a tight federation of societies and are least disruptive to research divisions that are already in existence.

"3. That the plans and tables of organizations in their initial form be circularized among the state and county medical societies with the reasons for the development and strong recommendations for affirmative action.

"4. That the Association hold a series of working meetings with state and county medical society executives, individually or in groups, to further refine the organizational patterns and procedures that will best serve them in this collective endeavor.

"XVII. That on implementation of the program for organization and reorganization, a planning council with appropriate subcommittees be formed for the purpose of processing data and formulating policy recommendations for consideration of the Board of Trustees of the House of Delegates.

FORMATION OF SUBCOMMITTEES

"XVIII. That the A.M.A. sponsor, promote the formation of, and participate in a 'National Academy of Health Professions for Research and Policy.' "

Editorial Note: These are the recommendations under the Himler Report. These recommendations are far reaching, and are of great concern to the majority of the members of the American Medical Association. The Minority Report has been submitted by John H. Budd, M.D. of Ohio, and considers both agreement and disagreement with the Himler Report. The Minority Report was considered by the Reference Committee as part of the complete report on the Committee on Planning and Development of the American Medical Association. It is difficult to give the Minority Report without giving the full-page, 60-page Himler Report; however, I will point out, or try to point out, the aspects that the Minority Report refers to.

1. From the Himler Report: "Further encroachments (on the time honored privileges, prerogatives and authorities of physicians) seem inevitable if the public is to get the health services it needs at a price that it is able, or willing, to pay."

Comment from the Budd Minority Report — "the soaring demand for health services and the reasons for it, as well as the predictions of demand outstripping capabilities, rising costs, depersonalization of physician-patient relationship are thoughtfully and accurately expounded; likewise, the need to attract into medicine the best qualified individuals in increasing numbers. However, on Page 5, Line 20, etc., I see no need for supporting further restriction of traditional privileges and freedoms; in Line 33, instead of the term 'minimal regimentation,' I prefer 'maximal professional independence and freedom of choice for both physician and patients.' Regimentation in any degree is not an incentive."

Editorial Note: The following are direct quotes from the Budd Report. Page and line references are related to the Himler Report.

"2. On Page 6, Line 6, the W.H.O. definition of health as it pertains to the field of medicine and the responsibility of the physician is extremely bad. It is, of course, utopian and, thus, doubtless desirable; but 'complete social well being' which involves satisfaction in financial, political, aesthetic, climatic, transportational, recreational and endless other areas seems to me beyond the responsibility, expertise, limits of time and physical capability of the medical profession. Assuming responsibility for conditions which appear well beyond the influence and control of the A.M.A. is to invite more criticism of the medical profession when their impossibility of attainment becomes evident.

"3. Page 6, Lines 43-44: I do not like the suggestion that 'restrainments on the authority and scope of activity of public health officials' precluded their success of leadership and the planning and implementation of health care programs, thus implying that their authority and scope of activity be extended (while those of physicians will, as warned, be abridged).

"A major contribution of the A.M.A. in 'bringing order to this chaotic field' (page 6, line 48) would be to encourage prudence and political promises, careful selection of achievable priorities and health goals, and restraint in committing taxpayers' money.

"4. Page 7, Line 51: 'People will support or at least not oppose the expenditure of large sums of tax money on broad programs for social welfare.' I believe the enthusiasm for such expenditures is cooling and will continue to wane. Rejection of proposed levies for school bonds, police and fire department salary increases and similar worthy purposes is increasingly common.

"5. Page 10, Line 32: 'In the past when either paid for medical services or received them from government.' This is neither a factual or fair statement. The alternatives for paying for medical services have not been limited to governmental bounty. True, government to some extent (and often in inadequate and penurious degree) financed some care, but much has been furnished by the personal benevolence of physicians and other philanthropic individuals. It should also be remembered that government does not provide 'medical services;' it only exacts taxes to pay for such care.

"6. Page 13, Line 30: That the shortage of physicians in rural communities is real and serious is agreed; but I do not believe that 'heavy patient loads and poor reimbursement,' especially the latter, are substantial reasons for the shortage in these communities, and I think such reference is unjust and may offend many such practitioners.

"7. Page 15, Paragraph 2: This section regarding manpower deficiencies is well done; the points made are good. I suggest it should be expanded to make clear the fact that the basic shortage is in the number of physicians *providing direct patient care* because of the many who are attracted into a) research, and b) education (both admittedly vitally necessary, always alluring, exalting and intellectually rewarding, free of the obligation and inconvenience of dealing directly with sick people, and, now, more adequately reimbursed); c) administrative medicine (insurance, industry, hospital operation, etc.), and d) the government, including those, of course, appropriated by the medical services.

"Much capricious, arbitrary and unfair criticism has been directed at the A.M.A. as being responsible for the shortage of physicians. The reasons just cited are beyond the influence and control of A.M.A., and this faction should be brought to public attention.

"8. On Page 18, Line 43 and in all places from here on where 'usual, customary, prevailing and reasonable' are referred to, especially where A.M.A. policy is concerned, the phrase should read only 'usual, customary and reasonable' even though, by implication, the 'prevailing' concept is included over the objection of a number of state delegations, including Ohio's.

"9. Page 19, Line 5: I am unable to agree that it is illogical for A.M.A. to 'call for objective experimentation in the organization of medical services and in the same breath express his preference for private, fee for service practice.' I do not believe it inconsistent to call H.E.W. to task for giving preferential *financial* support and subsidy to one form of medical practice and simultaneously express the Association's partiality for another. There is a difference, in my judgment, between providing funds (from taxpayers) to subsidize one form of organization for medical practice (H.E.W. action) and expressing a preference (A.M.A. action) while still advocating objective investigation and experimentation.

"10. Page 20, Paragraph 1: That other systems of practice are in some circumstances acceptable, appropriate, advisable, or even necessary is undeniable; but private practice should not be discouraged nor its support abandoned. I would be pleased to see the paragraph restated: 'In seeking as its goal the highest quality of patient care, the most effective use in regard to availability of the science and art of medicine, the Association advocates factual investigation and objective experimentation in new methods of delivery of health care, while still maintaining faith and trust in the private practice of medicine, and pride in this accomplishment.'

"11. Page 21, Line 3: 'There has been an appreciable increase in physicians' income since 1966 while, during the same time, the medical profession has been unable to bring about a material expansion of its capacity to deliver health services.' One of the reasons for increased income *is indeed* increased productivity and output by physicians working longer hours. It is true that use of automation, data processing, computer techniques in history recording and differential diagnosis, etc. are only a beginning and offer great possibilities; however, I consider gratuitous support of the frequently unwarranted criticism of physicians' incomes unnecessary and offensive.

"12. Page 23, Line 3: 'Medical Societies have absolutely no jurisdiction over the charges made by their members.'

"Medical societies have, indeed, rather severe jurisdiction over charges made by members when excessive. Peer review, honestly used, is a potent instrument and grossly excessive fees may be considered unethical; thus, the offending members may be subject to discipline by censure, suspension or expulsion. Though not legal power, this is effective if used. Furthermore, in Ohio, at least (and maybe other states as well), violation of the ethics of a professional society by a member can result in withdrawal of the offender's license by the State Board. This is legal power.

"13. Page 26, paragraphs 2, 3 and 4: The merits, legality, feasibility and attainable benefits of audit of physicians' office performance are complex questions. I am well aware of the risks and sometimes the existence of incompetence, negligence, exploitation, over-utilization, mal-utilization and other defects and deficiencies in the office, and it is true that the policing procedures usually present in the hospital are missing in the office. Whether the proposals for office audit are the most effective and least harmful, I am not prepared to say. My only plea in this complex problem is for caution and dispassionate judgment.

"14. Page 31, Line 8: The distrust and fear of government intrusion into medical practice, described as 'atavistic,' is indeed well founded and as justifiable as most primitive instincts. When politicians' promises become impossible to fulfill, the medical profession is usually held to blame. The current vilification of physicians generally for those Medicare inequities, costs and abuses for which the medical profession has little or no responsibility is disheartening.

"15. Page 37, Line 12: I do not approve the 51% consumer representation included in Public Law 89-749, and I agree with the well stated reasons in this paragraph. However, I would delete the last sentence in paragraph 2, page 37, line 17, beginning: 'Nevertheless, the intent of the law is clear. . . .' Compliance with the law is proper, but offering gratuitous endorsement is unnecessary.

"16. Page 38, beginning at Line 15: I would prefer the following construction: '1) Medical Societies at all levels should support the concept of Public Law 89-749 and the establishment of properly constituted planning agencies, provided, a) the area-wide comprehensive health planning agencies at local levels have broad community representation *on their Boards of Directors,* in contradistinction to their advisory committees and councils. It is inadvisable to permit local governments, composed as they are, of elected and appointed officials of varying capabilities and tenure, to dominate or control health planning; b) that medical societies have proper representation on the *executive bodies* of the planning councils. The societies should not accept a purely advisory function.' 2) 'to this end. . .' — this paragraph to be retained as in the text.

"17. Page 42, Line 2: Rather than 'create the general belief' which sounds like promoting deception, I prefer 'make it clear' as a more positive and accurate statement.

"18. Page 45, Lines 41-42: 'The Association's opposition to Medicare was more emotional than objective. . . .' I consider this a shocking denunciation. The accuracy and objectivity of the A.M.A.'s argument in opposition to Medicare are clear to me. A.M.A. warned of abuses, over-utilization, cost exceeding estimates, misunderstandings, inequities and failures which are now very evident. Most of the testimony before the House of Delegates' 1965 annual convention was, in fact, more objective than emotional. All A.M.A. testimony before Congressional committees was consistently objective.

"19. Page 47, Line 20, et seq.: I deem this an unjust appraisal of the physicians who comprise the House of Delegates. Having successful practices with patients derived mostly from middle and upper income brackets (though this is frequently not the case), being conservative in political and social philosophies, and being concerned with preserving the traditions of the profession and their time-honored relationships with their patients are not derogatory qualities, and I do not believe they preclude objective judgment by honorable men. Criticism, to be sure, is offensive when unwarranted, but I do not think most physicians are resentful of legitimate criticism."

Dr. Budd points out that this list is partial. He points out that his purpose is not to destroy a comprehensive document or to malign a committee, but he feels that his criticisms are intended to be constructive.

It is unfortunate that, although your editor has quoted the Minority Report almost verbatim, I find it impossible to quote the 60-page report of the Himler Report verbatim; however, I felt that this is the way it should be recorded. Those of you who desire further delineation of the complete Himler Report can derive this from the Medical Society offices.

The intent of this editorial is to get some suggestions from the membership as a whole as to their desires regarding the Himler Report and the Minority Report as presented. Your Society and your delegates to the A.M.A. would like a response from the membership on their desires and feelings on the recommendations promulgated. Your feelings may be expressed by your correspondence to the Chairman of the Council of the State Medical Society, Ross V. Taylor, M.D., to your Chairman of the Delegates to the A.M.A. Doctor Sweeny, or to your editorial board. All will be considered and acted upon. It is felt that these recommendations are of great import to the future of the Medical Society as a whole and that they should create deliberation and answer on your part as members of the State Medical Society, members of the American Medical Association and citizens of the United States.

—John W. Moses, M.D.
MSMS Scientific Editor
MSMS Delegate to the AMA

Maternal Health Conference Speakers Headed By Doctor Prystowsky of Florida

Keynote speaker for the ninth annual Michigan Conference on Maternal and Perinatal Health March 25-26 in Flint will be Harry Prystowsky, M.D., professor and chairman, Obstetrics and Gynecology, the University of Florida College of Medicine.

Doctor Prystowsky

Doctor Prystowsky, who has held his present post since 1958 and before that was an assistant professor at Johns Hopkins University and Hospital, will discuss "The University Role in the Delivery of Health Care."

He has been associated with 21 professional societies, having been president of the Association of Professors of Gynecology and Obstetrics, Florida section chairman for the American College of Obstetricians and Gynecologists and the Council of Academic Societies of the Association of American Medical Colleges.

Doctor Prystowsky has served as a consultant in obstetrics and gynecology to the Surgeon General, U.S. Air Force, and HEW; been a recipient of the Ten Outstanding Young Men Award of the U.S. Jaycees, and is a consultant to the 1970 White House Conference on Children and Youth.

He has been chairman of the Education and Public Relations Committee of the American Association of Planned Parenthood Physicians, a member of the National Council of Obstetrics and Gynecology of the American College of Obstetrics and Gynecology, the Council of the American Gynecological Society, the Executive Committee of the National Council of Obstetrics and Gynecology and the Advisory Policy Committee of the American Journal of Obstetrics and Gynecology.

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Michigan Society of Obstetricians, Gynecologists Co-sponsoring Maternal Health Conference March 25-26

A special reminder to attend the 1970 Michigan Conference on Maternal and Perinatal Health is made to all Michigan obstetricians and gynecologists by Ralph Steffe, M.D., the president-elect of the Michigan Society of Obstetricians and Gynecologists.

No registration fee is charged to those attending the conference, scheduled March 25-26 at the Pick-Durant Hotel, Flint. The Michigan Society of Obstetricians and Gynecologists is co-sponsoring the conference for the first time this year with MSMS and the Clara Elizabeth Fund of Flint. Interested physicians should use the advance registration form mailed to them or call the MSMS Headquarters in East Lansing.

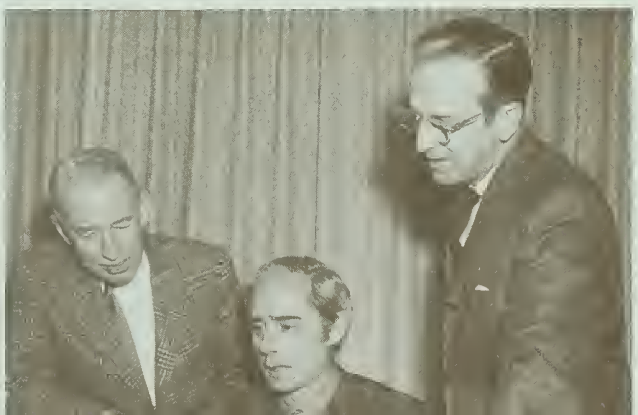
MSMS Takes Several Steps To Counteract U.S. Senate Report on Medicare, Medicaid

County Medical Society presidents received a report February 11 from Ross V. Taylor, M.D., Chairman, MSMS Council, outlining steps being taken by MSMS "to help counteract the adverse publicity the medical profession has received from the report of the U. S. Senate Finance Committee staff on Medicare and Medicaid."

Both the AMA and MSMS declared that efforts would be taken to help the government root out any abuses, as charged.

Both the AMA and MSMS will seek to describe to the public the long-standing machinery of peer review as the profession's way to help measure quality of service.

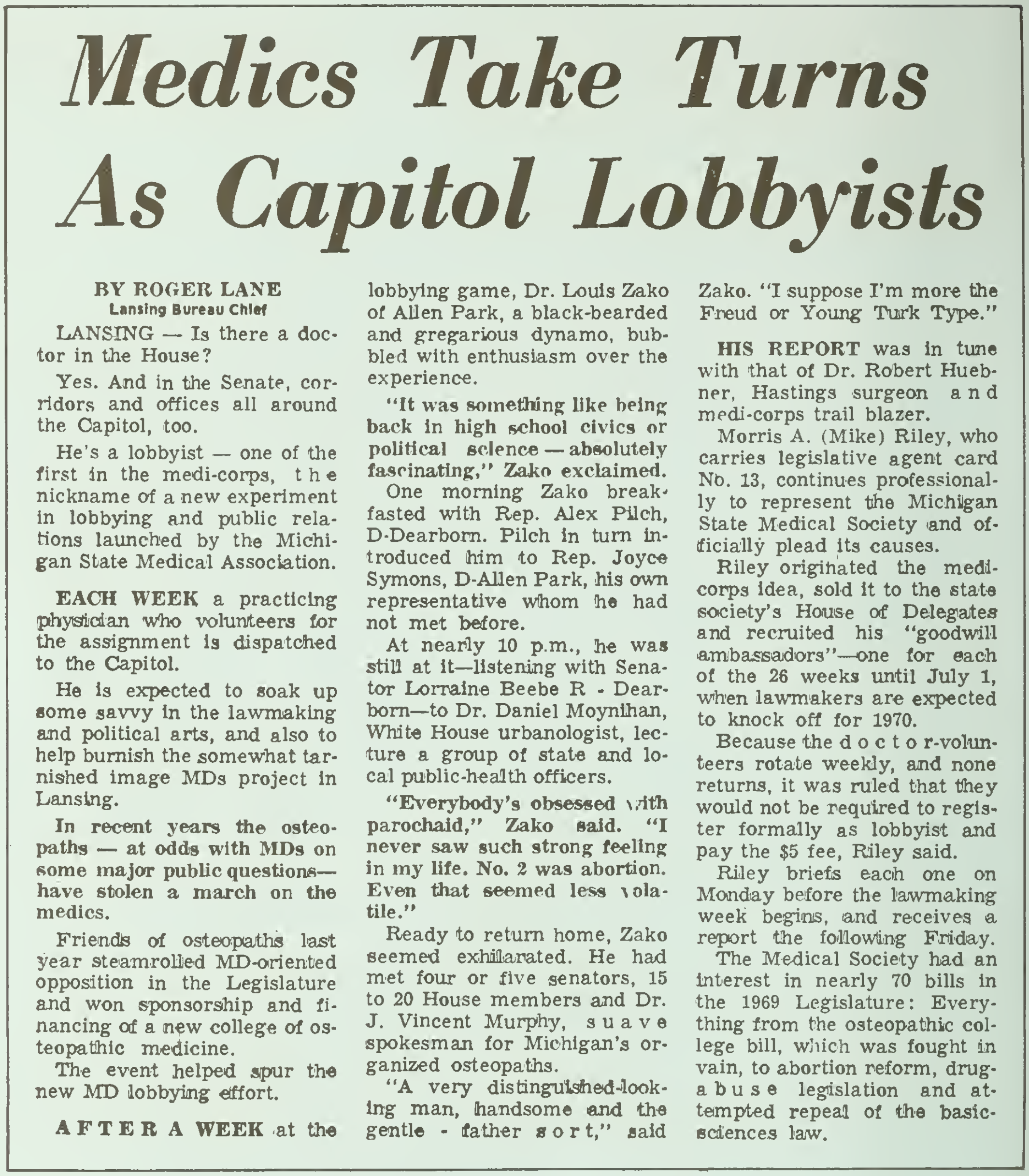
One of the special MSMS educational efforts will be a MAP Formula television program at 6 p.m., Sunday, March 8 over WJIM-TV to explain the peer review programs carried out by the medical profession in hospitals.



MSMS's new standing Committee on Planning and Priorities, chaired by Brooker L. Masters, M.D., Fremont, center, met for the first time recently at MSMS Headquarters. Present were James B. Blodgett, M.D., Royal Oak, left, Speaker of the MSMS House of Delegates, and John J. Coury, M.D., Port Huron, member of The MSMS Council. Other members are H. F. Falls, M.D., Ann Arbor, A. C. McClay, M.D., Traverse City, and Milton R. Weed, M.D., Grosse Pointe Park.

MSMS Volunteer Physician Representatives Featured in DETROIT FREE PRESS Article

(The following article on the new Volunteer Physician Representatives for MSMS is reprinted from the Feb. 11 edition of the DETROIT FREE PRESS. A feature article on the experiences of the first volunteer, R. J. Huebner, M.D., Hastings, appears on page 244 of this issue of MICHIGAN MEDICINE.)



Medics Take Turns As Capitol Lobbyists

BY ROGER LANE
Lansing Bureau Chief

LANSING — Is there a doctor in the House?

Yes. And in the Senate, corridors and offices all around the Capitol, too.

He's a lobbyist — one of the first in the medi-corps, the nickname of a new experiment in lobbying and public relations launched by the Michigan State Medical Association.

EACH WEEK a practicing physician who volunteers for the assignment is dispatched to the Capitol.

He is expected to soak up some savvy in the lawmaking and political arts, and also to help burnish the somewhat tarnished image MDs project in Lansing.

In recent years the osteopaths — at odds with MDs on some major public questions— have stolen a march on the medics.

Friends of osteopaths last year steamrolled MD-oriented opposition in the Legislature and won sponsorship and financing of a new college of osteopathic medicine.

The event helped spur the new MD lobbying effort.

AFTER A WEEK at the lobbying game, Dr. Louis Zako of Allen Park, a black-bearded and gregarious dynamo, bubbled with enthusiasm over the experience.

"It was something like being back in high school civics or political science — absolutely fascinating," Zako exclaimed.

One morning Zako breakfasted with Rep. Alex Pilch, D-Dearborn. Pilch in turn introduced him to Rep. Joyce Symons, D-Allen Park, his own representative whom he had not met before.

At nearly 10 p.m., he was still at it—listening with Senator Lorraine Beebe R - Dearborn—to Dr. Daniel Moynihan, White House urbanologist, lecture a group of state and local public-health officers.

"Everybody's obsessed with parochaid," Zako said. "I never saw such strong feeling in my life. No. 2 was abortion. Even that seemed less volatile."

Ready to return home, Zako seemed exhilarated. He had met four or five senators, 15 to 20 House members and Dr. J. Vincent Murphy, suave spokesman for Michigan's organized osteopaths.

"A very distinguished-looking man, handsome and the gentle - father sort," said Zako. "I suppose I'm more the Freud or Young Turk Type."

HIS REPORT was in tune with that of Dr. Robert Huebner, Hastings surgeon and medi-corps trail blazer.

Morris A. (Mike) Riley, who carries legislative agent card No. 13, continues professionally to represent the Michigan State Medical Society and officially plead its causes.

Riley originated the medi-corps idea, sold it to the state society's House of Delegates and recruited his "goodwill ambassadors"—one for each of the 26 weeks until July 1, when lawmakers are expected to knock off for 1970.

Because the doctor-volunteers rotate weekly, and none returns, it was ruled that they would not be required to register formally as lobbyist and pay the $5 fee, Riley said.

Riley briefs each one on Monday before the lawmaking week begins, and receives a report the following Friday.

The Medical Society had an interest in nearly 70 bills in the 1969 Legislature: Everything from the osteopathic college bill, which was fought in vain, to abortion reform, drug-abuse legislation and attempted repeal of the basic-sciences law.

Problems of Grief Keynote Topic For Medicine-Religion Workshop April 1 in Detroit

"Good Grief — A Constructive Approach to the Problems of Loss," will be the subject of the keynote speech to be delivered at the Medicine and Religion Workshop planned April 1 in Detroit by MSMS and the Wayne County Medical Societies.

Keynote speaker will be the Rev. G. E. Westburg, Hamma School of Theology, Wittenberg University, Springfield, Ohio. The afternoon and evening workshop, for county medical society presidents, members of county medicine and religion committees and their clergymen, will be held at the WCMS Headquarters, 1010 Antietam, Detroit.

At a recent meeting, members of the MSMS Committee on Highway Injuries, chaired by Paul W. Gikas, M.D., Ann Arbor, center, heard a preliminary report from Douglas Fryer, M.D., right, chief, Developmental Services, MDPH, about a survey of ambulance services in Michigan being conducted by the Public Health Department. They also heard Charles Frey, M.D., Ann Arbor, chairman of the Highway Injuries Committee's new subcommittee on emergency medical service, tell of a proposed June meeting for all those who provide emergency medical services in the state.

OFFICIAL PORTRAIT of the first Medical Evaluation and Advisory Group to the Secretary of State to decide whether motorists are medically capable of driving a vehicle, includes from left, back row, Park W. Willis, III, M.D., Ann Arbor; John F. Simpson, M.D., Ann Arbor; Roger L. Kuhlman, O.D., Grand Ledge; and James L. Grisell, Ph.D., Detroit. In front, from left, are Lee F. Bartholomew, M.D., Ann Arbor; Robert T. Blackhurst, M.D., Midland, chairman of the MSMS Committee on Eye Care; Robert L. Curtiss, D.O., Grand Rapids; Douglas Fryer, M.D., Lansing, and Jacques S. Gottlieb, M.D., Detroit. The group was formed according to a federal highway safety act of 1966, and has been a goal of MSMS's Committee on Highway Injuries since 1967.

MSMS Gastroenterology Section, Saginaw County Medical Society to Meet

The MSMS Gastroenterology Section and the Saginaw County Medical Society will hold a joint meeting March 19 at the Ramada Inn, Saginaw. Interested physicians may obtain a program from C. Peter Behme, M.D., 5160 Helga Drive, Saginaw 48603.

Nine MSMS Members Attend AMA-AMPAC Workshop Feb. 28 - March 1 in Washington

Donato F. Sarapo, M.D., Adrian, led a delegation of nine Michigan physicians to the annual AMA-AMPAC Workshop Feb. 28-March 1 in Washington, D.C. Top government officials and lawmakers provided a rundown on the political picture, with special emphasis on the 1970 elections.

Physicians accompanying Doctor Sarapo were Alexander Blain, III, M.D., Detroit; Frederick W. Engstrom, M.D., Dearborn; Glen E. Moore, M.D., Flint; Robert J. Fisher, M.D., Ypsilanti; Leonard Howard, MD., Battle Creek; Robert Perry, M.D., Lansing; Robert M. Leitch, M.D., Union City, and James Fryfogle, M.D., Detroit.

Michigan Physicians Participate in AMA Congress on Education

CHICAGO — Many Michigan physicians participated in the AMA 66th Annual Congress on Medical Education here, and heard major addresses by national leaders — including several Michigan men. Four different groups met under the Congress umbrella. Michigan speakers at the

AMONG REGISTRANTS for the Renal Transplantation Conference sponsored recently by the Kidney Foundation of Michigan in cooperation with Wayne State University, The University of Michigan and Henry Ford Hospital were from left, John M. Weller, M.D., Ann Arbor; James M. Pierce, Jr., M.D., Detroit, and J. C. Rosenberg, M.D., Detroit.

AMONG 300 physicians who attended the recent Harold C. Mack Symposium on Physiology and Pathology of Reproduction at Wayne State University School of Medicine were, from left, Harold C. Mack, M.D., Leonard Heath, M.D., and T. N. Evans, M.D., chairman, all of the WSU Ob/Gyn Dept. Doctor Mack, for whom the conference is named, was chairman of obstetrics at WSU.

MSMS MEMBERS AT AMA CONGRESS/Continued

February 8-9 AMA Council on Medical Education's program were Andrew D. Hunt, Jr., M.D., MSU dean; Hilliard K. Jason, M.D., Ed.D., also of MSU; Joseph W. Hess, M.D., WSU, and two medical students, Joel Morganroth, U-M, and Kenneth Hekman, WSU. More details will appear in the April issue of *Michigan Medicine.*

MSMS Council Re-elects, Reappoints Officers at Annual Meeting

The MSMS Council, at its Jan. 28 annual meeting at MSMS Headquarters, re-elected its secretary, assistant secretary, treasurer, assistant treasurer, and scientific editor of *Michigan Medicine.* The Council reappointed the executive director and associate director of the society.

Continuing in those positions are Kenneth H. Johnson, M.D., Lansing, secretary; Brooker L. Masters, M.D., Fremont, assistant secretary; John R. Ylvisaker, M.D., Lansing, treasurer; C. Allen Payne, M.D., Grand Rapids, assistant treasurer; and John W. Moses, M.D., Detroit, scientific editor of the journal. Hugh W. Brenneman was reappointed executive director and Warren F. Tryloff was reappointed associate executive director.

Doctor Gronvall Appointed Acting Dean, U-M Medical School

John A. Gronvall, M.D., associate dean of the University of Michigan Medical School, has been appointed acting dean and acting director of the Medical Center by the University's Regents.

Doctor Gronvall will fill the vacancy created when William N. Hubbard, Jr., M.D., leaves April 1 to join the Upjohn Co. Doctor Gronvall joined the U-M staff in 1968 as associate dean and associate professor of pathology. A committee of 12, including three students, has been appointed to find a successor to Doctor Hubbard. John W. Henderson, M.D., chairman of the U-M Ophthalmology Department, is chairman of the committee.

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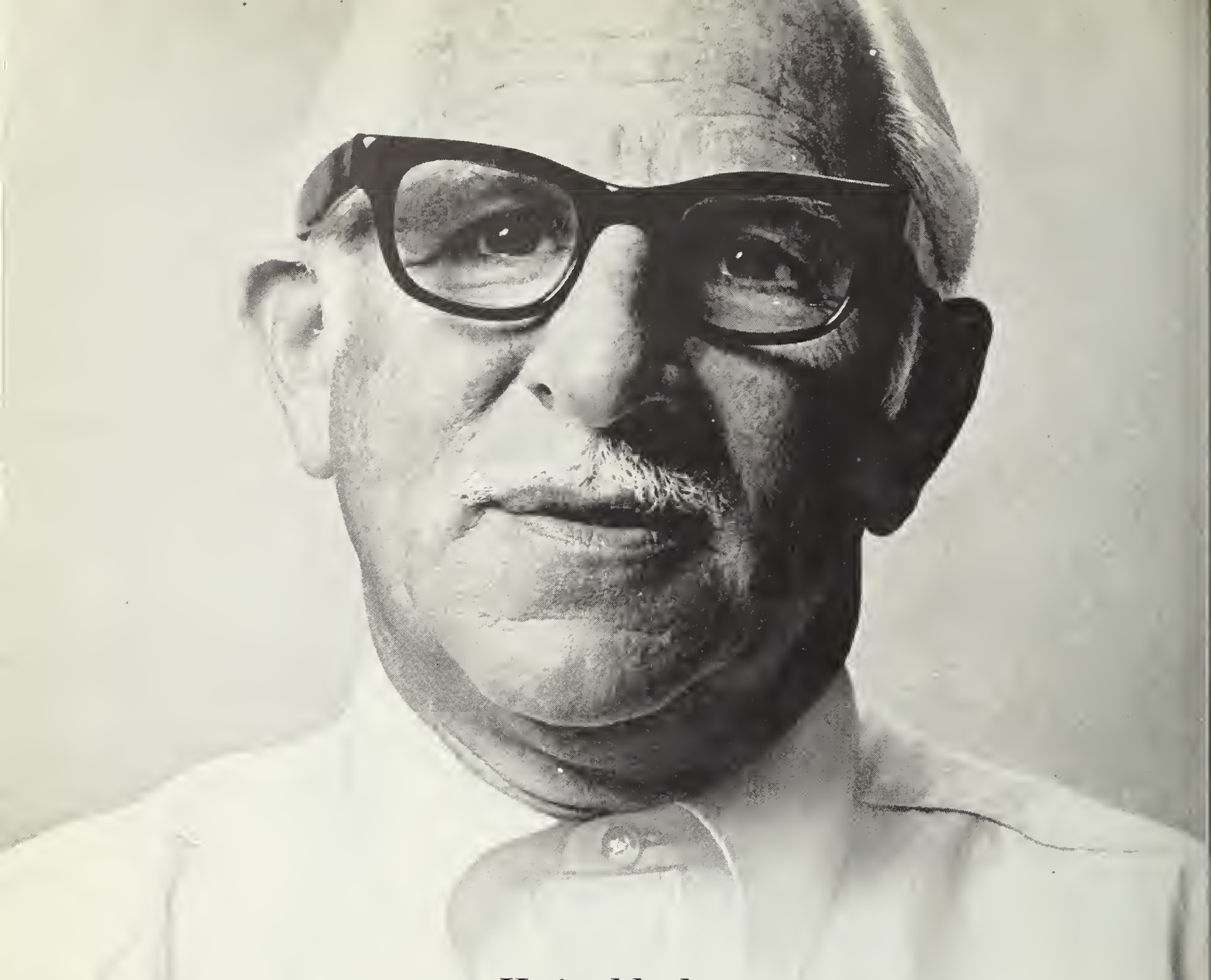

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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

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MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

IN THIS ISSUE

The cover art is a reproduction of a lithograph by Paul Wunderlich, a contemporary German artist. This print, from a portfolio, "Kleine Anatomie," was purchased by the Ars Medica Collection from monies left over from the voluntary contributions of Michigan doctors when the Ars Medica exhibition was brought to the Detroit Art Gallery during the 1968 MSMS Annual Session. The print is reproduced with the permission of the Philadelphia Museum of Art.

SCIENTIFIC ARTICLES

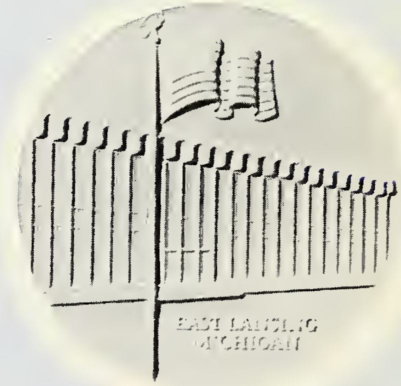
209 Amniocentesis Technic, Applications and Complications; Bernard Mandelbaum, M.D.
215 Treatment with Thioridazine of Emotionally Disturbed Children in a Day Hospital; Pedro A. Ojeda, M.D.
219 Management of the Moribund Asthmatic Patient; Robert G. Lovell, M.D.; Lawrence Preuss, M.D.; Richard L. White, M.D.
221 Viral Infections in a Large Urban Hospital; Manoochehr Agah, M.D., M.P.H.; Maurice Becker, Ph.D.

SPECIAL ARTICLES

198 MSMS Statement on Sex Education
229 Evaluation of State Patients in Nursing Homes; Hermann A. Ziel, Jr., M.D.
244 A Week with the Legislature; Judith Marr

OTHER FEATURES

191 breaking news
200 msms leadership
201 officers' page
205 your opinion please
233 about doctors
236 editorial viewpoints
240 msms news
michigan mediscene
251 socio-economics
254 ancillary
261 medical care programs
264 county societies
268 in memoriam
272 noted and quoted



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MSMS Statement on Sex Education Endorses Proposed State Guidelines

In a position statement made public at two February news conferences, the Michigan State Medical Society has refuted the critics of sex education in the schools, and endorsed the guidelines for sex education recommended by an advisory committee to the State Board of Education.

MSMS President Robert J. Mason, M.D., Birmingham, and Eleanor Skufis, M.D., Adrian, MSMS Maternal and Perinatal Health committee advisor, conducted news conferences Feb. 4 and 5 in Detroit and Lansing, respectively.

It was then that MSMS made known the adoption Jan. 28 by The Council of a new Position Statement on the Teaching of Sex Education, recommended by the MSMS Committee on Maternal and Perinatal Health.

Before adopting the new statement, MSMS carefully evaluated the recommendations for family life and sex education programs from the Joint AMA and NEA Committee on Health Problems; the Governor's Task Force on Family Living, 1967; the Guidelines for Sex Education, the Advisory Committee on Sex Education of the Michigan State Board of Education, 1969, and the family life education program of the Committee on Maternal Health of the MSMS, accepted by The Council in 1968.

"MSMS FINDS nothing in these reports and guidelines which suggests the teaching of 'raw sex' to immature minds, but only carefully prepared guidelines for the teaching of human sexuality to our children at the appropriate levels of maturation," answers the statement to critics of all sex education.

The statement continues: "MSMS believes the Guidelines for Sex Education recommended by the Michigan State Board of Education Advisory Committee on Sex Education properly implement the Michigan State Senate Bill No. 925 which became Public Law No. 44, 1968."

The State Board of Education, after many stormy hearings across the state, sent the proposed guidelines to the State Attorney General's office for legal rulings, and referred some of the guidelines to staff for minor revisions.

The statement recommends the state advisory committee's guidelines for family life and sex education be vigorously supported by Michigan physicians and that the state's doctors "actively refute the irresponsible and ridiculous charges of the opponents of any and all sex education in the schools of Michigan."

The MSMS position is that adequate family life and sex education programs will help our children adjust to the changing world and help them cope with health problems, both physical and emotional.

MSMS DEFINES family life and sex education as a positive approach to strengthening the family for its vital tasks for nurturing healthy personalities, developing sound values and fostering satisfying, constructive human relations.

Family life and sex education are the primary responsibility of home and church, says the statement, in part; yet too few parents feel adequate to give their children expert preparation on the subject.

MSMS firmly believes that voluntary family life and sex education programs ought to be evolved by each community to suit its own needs, and that the physicians of Michigan, by the nature of their training, are particularly well qualified to serve in an advisory capacity for the formation of local programs.

THE POSITION PAPER lists eight objectives of "developing sane sex education programs":

1) to help children understand the living world around them

2) to provide knowledge and understanding of human physical and emotional growth and maturation at appropriate educational levels

3) to promote knowledge and respect for the human reproduction function

4) to prepare the student for the physical and emotional changes he will undergo

5) to help the student attain a knowledge and understanding of male and female anatomy and physiology

6) to provide knowledge that will help young people to approach marriage and establish homes with something more than good intentions and unrealistic expectations

7) to increase understanding of communicable disease and disease control, including venereal diseases

8) to increase knowledge of substances harmful to the body such as narcotics, alcohol and tobacco.

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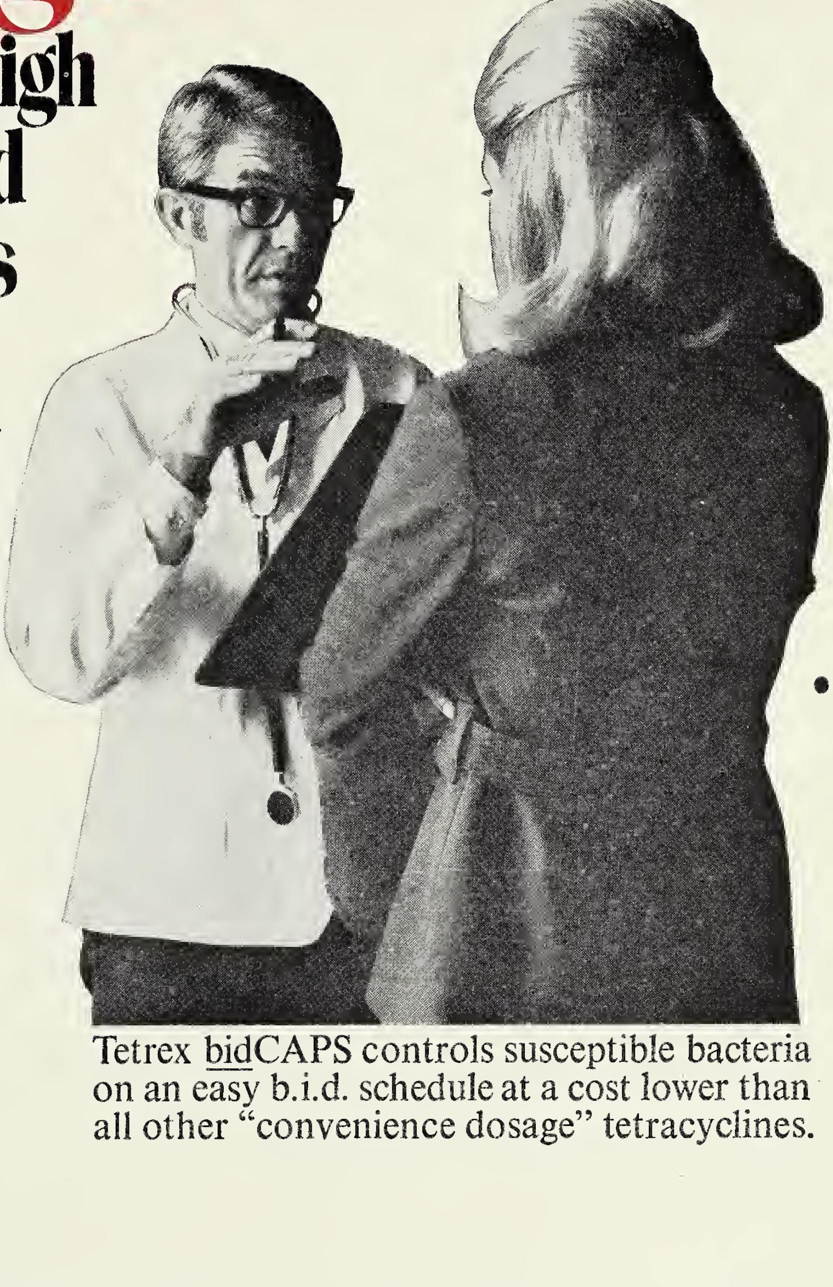

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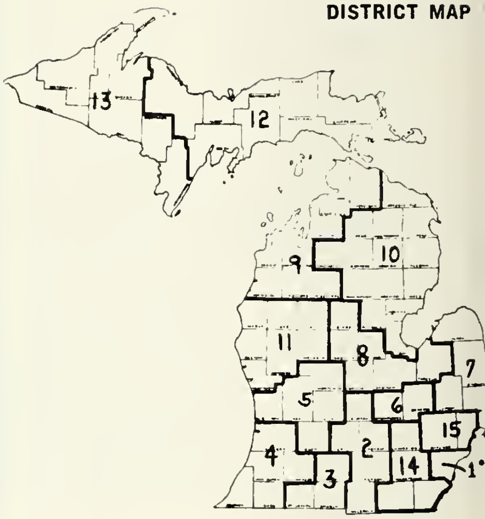

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"A Republic If You Can Keep It."

Ben Franklin was asked as he left Constitution Hall, "What kind of a government have you given us?" He replied, "A republic if you can keep it."

Similarly, your Michigan State Medical Society and the American Medical Association are a republic — if you can keep it.

Each county medical society sends a delegate (for each 50 members or major fraction thereof) to the MSMS House of Delegates. The House of Delegates in a working session of approximately three days responds to the important issues and situations it faces and sets policy for the association. When in session, it acts on all resolutions presented by individual members, societies, committees, and council.

POLICY DECISIONS in the form of resolutions and recommendations are referred to reference committees that hear testimony from all members of the state society, and such technical and professional advice as needed. They present their reports to the House of Delegates that approves, rejects or amends, and in this way policy decisions are made.

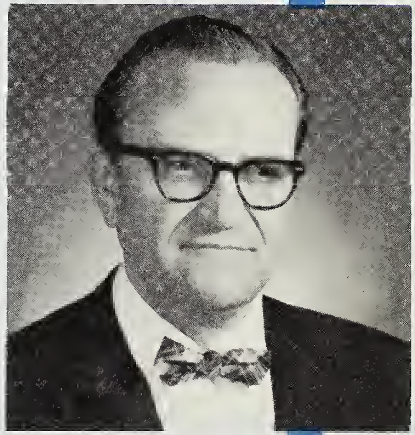
The House of Delegates elects all officers (president-elect, president, speaker, vice speaker, councilors, and the directors of Blue Shield). Between meetings, The Council, elected by the delegates on a geographic district basis, carries out the policy and runs the business of the society. The Council elects its chairman, vice chairman and committee chairman, executive staff, the secretary and assistant secretary, the treasurer and assistant treasurer of the society.

The House of Delegates, the president, and The Council appoint standing, special, and ad hoc committees — to assist in carrying out their responsibilities.

THE FINAL authority rests in the House of Delegates and should a major change in policy be necessary, the House can be called to a special session.

The Michigan State Medical Society House of Delegates elects eight delegates to the American Medical Association and an equal number of alternates for two-year staggered terms. The AMA is a loose federation of 50 state medical societies and societies from the District of Columbia, Virgin Islands, Canal Zone, and Puerto Rico. These constituent associations send delegates in proportion to their membership. The American Medical Association headquarters elect all trustees, officers, and councils; so it, too, is representative in form and responds to local pressures.

SO YOU have a voice! You must be informed and instruct your representatives so they can reflect your desires. Apathetic, — and let-George-do-it attitudes must give way to responsive, concerned, dynamic leadership, for the physician, his patient, and America.



Vernon V. Bass, M.D.
Vice Speaker
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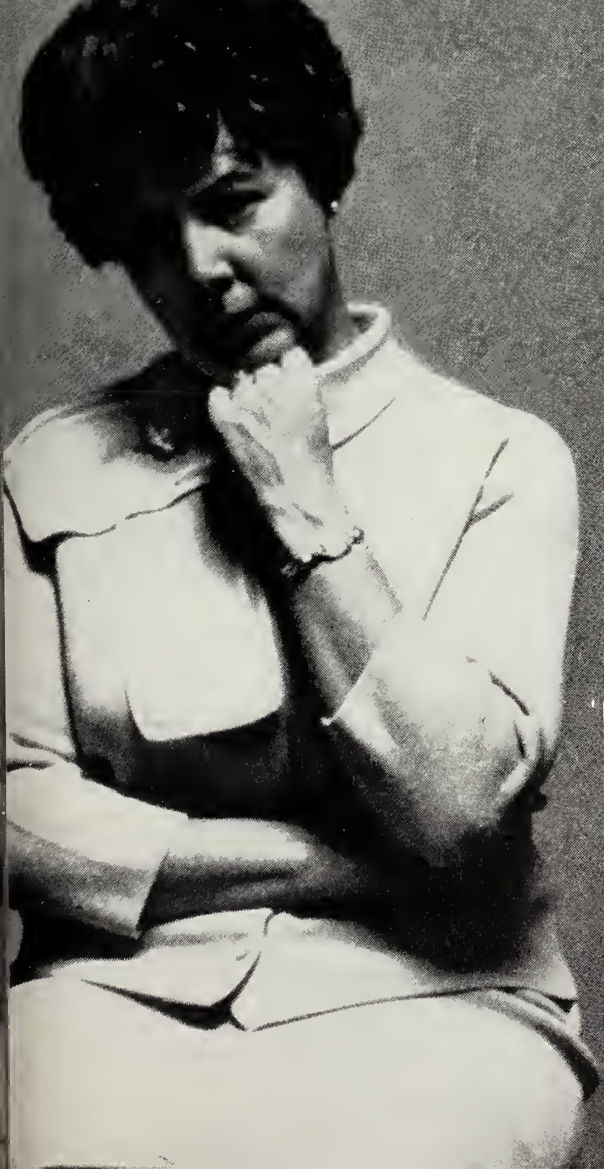

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REVISED PRESCRIBING INFORMATION

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Indications: Symptomatic relief of adult rheumatoid and degenerative joint disease unresponsive to adequate trial of salicylates and other measures of established value, such as appropriate rest. Has been found effective in active stages of: 1) moderate to severe rheumatoid arthritis including acute flares of chronic disease, 2) moderate to severe rheumatoid (ankylosing) spondylitis, and 3) moderate to severe degenerative joint disease of the hip (osteoarthritis of the hip). Has been found effective in relieving pain and reducing fever, swelling, and tenderness in acute gouty arthritis in selected patients. May enable reduction of steroid dosage in patients receiving steroids for the more severe forms of rheumatoid arthritis; in such instances the steroid dosage should be reduced slowly and the patients followed very closely for any possible adverse effects.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

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your opinion please

Do you believe the medical profession is successfully meeting its professional obligations in the area of peer review and if not how could the profession improve its leadership in this field?

Joseph V. Fisher, M.D.
Chelsea

The mechanics exist for peer review in most hospitals today. Tissue Review committees provide surveillance and control of surgical procedures: Utilization Review Committees investigate and exercise guidance in the proper use of available hospital beds.

In our own county medical society two committees function to play a role in peer review. The Ethics Committee holds a group session for all new members at which time such topics as hospital staff membership, the role of organized medicine, ethical and professional conduct, "conspicuous consumption," etc., are discussed and interpreted. The Grievance Committee hears, investigates and rules on complaints of alleged misconduct by our members.

The aforementioned are commendable methods but perhaps the most effective means of "peer review" is that which the physician exercises on himself. While admittedly subjective, a periodic self inventory can be a revealing and salutary experience. In the last analysis this form of control represents our best hope to keep our profession both honorable and free.

Roscoe V. Stuber, M.D.
Howell

Recently the legal profession has come into criticism in our state for its difficulty in disciplining members who have committed unethical acts. Physicians have also been criticized for their "closed shop" in organized medicine and "burying their mistakes." Stories have appeared in the newspapers which point up how difficult it is for a physician to have his license revoked in spite of confirmed unethical acts. There are many articles about the high cost of medical and surgical care today.

We seem to rely upon the Community Hospitals to primarily regulate physicians on their staff. With the organized structure necessary in all accredited hospitals considerable peer review is obligatory. This makes most admissions necessary, surgery adequate and indicated, and discharges fairly prompt. Blue Shield also helps keep tabs on the participating physician. Fear of being sued may actually encourage a higher quality of medical practice in some cases.

How do we have more adequate checks on the physician without loss of personal freedom? Perhaps we need to use our County Societies committees on ethics and grievances more frequently. Communications between doctors must include open, frank criticism to each other. If we do not soon better police ourselves, keep our fees voluntarily at reasonable levels, and have a sincere Christian concern for our patients, our fees will soon be set by the Government and utilization procedures even more rigidly imposed.

Kenneth E. Rowe, M.D.
Calumet

Members of the medical profession have been active in the area of peer review for many years as members of organized hospital staffs. The tissue committees, infection committees, and other committees as well as the screening of applications for hospital staff priviliges have acted as peer reviews intended to maintain the quality of medical practice in those facilities at a high level. The advent of Medicare and Medicaid with its utilization review committees has thrust physicians into review of the appropriateness of care in hospitals. In general, this peer review has tended to maintain a high quality of care in the hospital and a corresponding good quality of care practiced by the individual physician.

There are exceptions, however, and unfortunately Medicare and financial gain have been involved. These peer review failures have been made public record and the example by which the physician, in general, is judged by the public and press media. The medical profession needs expert leadership in the area of correction of abuse of Title XVIII and XIX by physicians.

Another area of peer review where the profession has fallen down is in the area of continuing education for physicians. A large number of physicians keep current, but there is no provision to prevent numerous exceptions. Leadership has been exerted in providing for courses but, unfortunately, the licensing boards and the specialty certification boards have done little or nothing to require the updating of physicians' knowledge which we all know is required to maintain high quality of care. The American Academy of General Practice is an exception. The entire profession can follow the lead of A.A.G.P. which at least has addressed itself to the problem of review of current knowledge by which the academy reviews the educational preparation of its members.

Are Continuing Medical Education Obligations Met?

"Your Opinion Please" is a new monthly feature in *Michigan Medicine* providing coverage of the views of more Michigan physicians on vital issues. Your comments are invited in response to the question asked on this page.

A question will be selected each month and interested physicians are urged to send in their reactions. Letters in response to the question for the May issue must be received in the MSMS office by April 1.

The May question will be:

"Do you believe the medical profession is successfully meeting its professional obligations in providing opportunities for continuing medical education? How could the medical profession further meet its responsibilities?"

Brooker L. Masters, M.D.
Chairman
Publication Committee

Orlen J. Johnson, M.D.
Bay City

Effort in the area of peer review is feeble at best. After licensure and obtaining institutional privileges, only flagrant and dire conduct receives punitive discipline after the fact. Boards of licensure hide behind legislated restrictions "in the act," medical societies and staffs in actuality have limited ineffective activity because of disinterest and personal protectiveness.

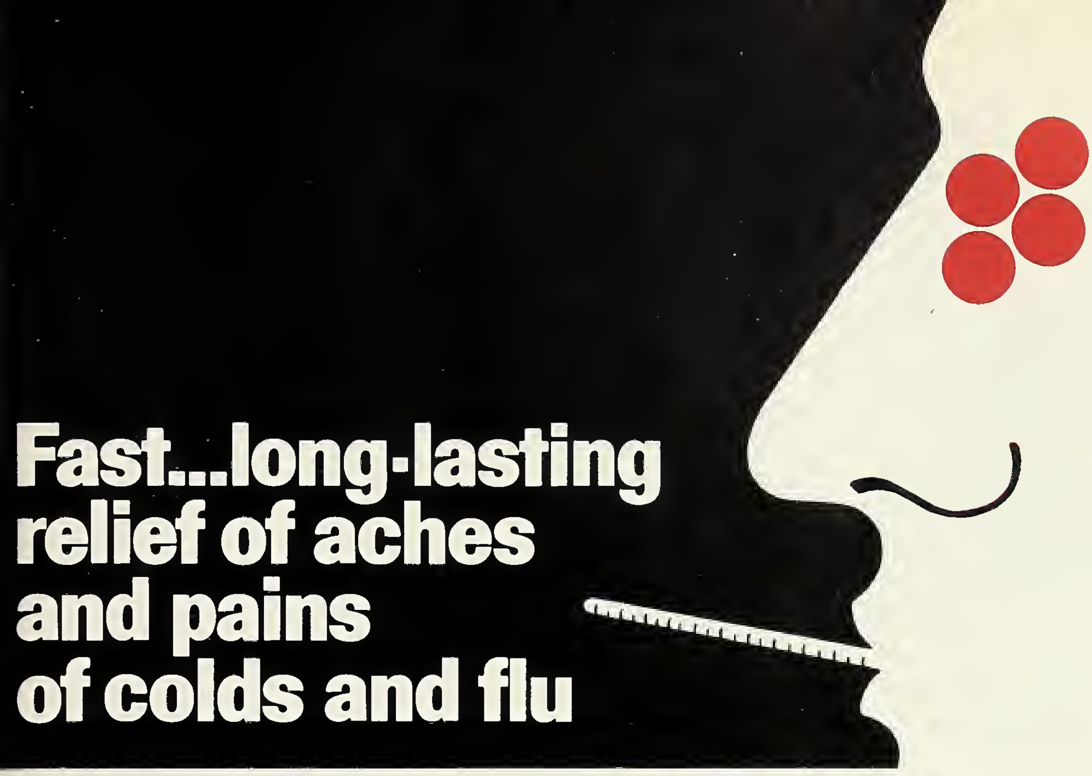
The medical profession long has worked for and urged legislative enactment which would make possible control of improper as well as illegal professional conduct. In this area sanctioned cooperation between the profession as a whole and the necessarily numerically-limited legal board could result in broader and better control. Efforts in this direction are thwarted by political manipulation in legislatures. This makes some wary of opening "Pandora's box" and ending up with a poorer act.

The most emphasis currently is on utilization not only in government but equally in private programs. In the face of warnings by the medical profession the socialists provided the politicians with a campaign gimmick. Now the medical profession is charged with pulling their chestnuts out of the fire. The profession is being made the scapegoat of the politicians' irresponsibility.

The private health care plans are selling unrealistic programs to the public to compete in the market place. Again the medical profession is being charged with this "over sell." Medical costs are grouped in health care whereas they are a small fraction of health costs.

Regarding that as it is we still have the responsibility of overcoming the conduct of that ubiquitous 5% which reflects on the profession as a whole. Scrutiny by our peers by the conscientious effort of utilization committees is far above that of members of Congress.

Still we cannot and must not be delinquent in our responsibility. We have the vehicles through utilization, credential, ethics and mediation committees for continuous scrutinizing of our professional conduct in all areas. We cannot shirk because of irresponsible propaganda of socialists and politicians.



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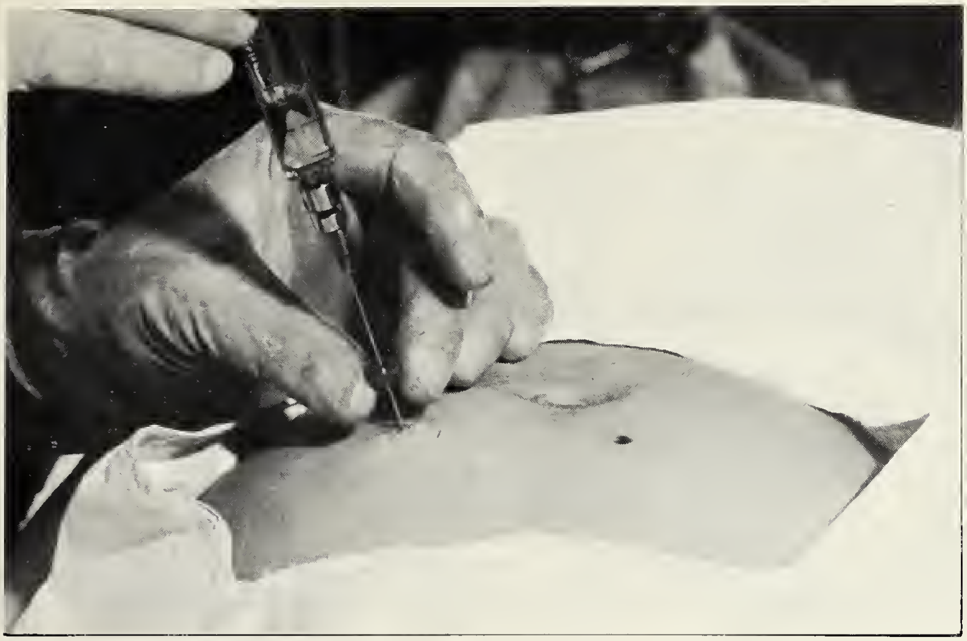

Fig. 1 — Amniocentesis performed with aseptic technic. The short needle avoids contact of the amniocentesis needle with the maternal skin.

Amniocentesis Technic, Applications and Complications

BY BERNARD MANDELBAUM, M.D.
DETROIT, MICHIGAN

Transabdominal amniocentesis has been used in the treatment of polyhydramnios, localization of the placenta, measurement of intrauterine pressures, and in the management of Rh sensitized pregnancies. Manees, Miller and Holly[1] introduced amniography in 1930. Its relative safety has extended its use as an important obstetrical tool.

TECHNIC

The bladder is emptied and rigid asepsis applied (**Fig. 1**). The needle is introduced in an area close to, but not in contact with the fetus. When fetal parts are easily palpable, intervening placenta is unlikely. The best areas for insertion of the needle are: the triangle of the small parts or adjacent to the nape when it is clearly identified (**Fig. 2**). In a vertex presentation, the unengaged head can be displaced upwards or laterally and held in position. The needle is introduced close to the operator's fingers (**Fig. 3**). With an engaged head and a larger baby, the area of the nape or any other area close to the fetal head can be selected when the small parts are not palpated (**Fig. 4**). In a breech presentation, the head can be displaced laterally (**Fig. 5**).

A $1\frac{1}{2}$-inch 18-gauge needle with stylet is passed through the maternal skin and the subcutaneous tissue under local anesthesia and the stylet withdrawn. A 5-inch 20-gauge spinal needle with stylet is inserted through the larger needle avoiding

scientific papers

The author is assistant professor in the Department of Gynecology and Obstetrics at Wayne State University School of Medicine, Detroit.

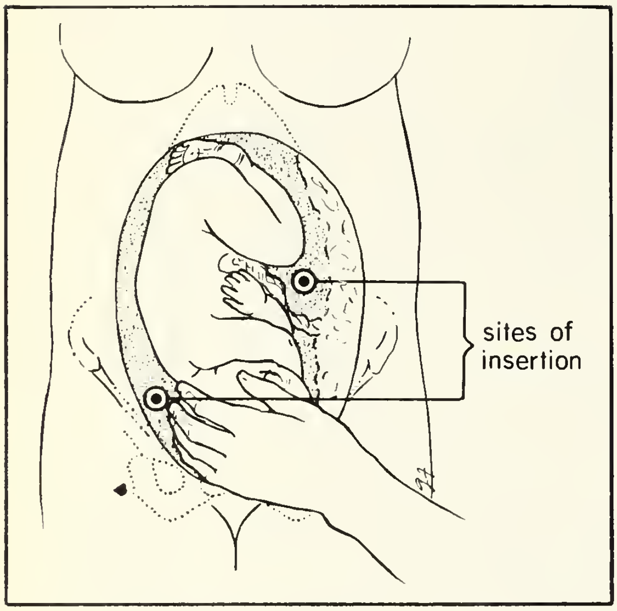
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Fig. 2 — The two most common areas for amniocentesis: the area of the small parts and adjacent to the fetal nape.

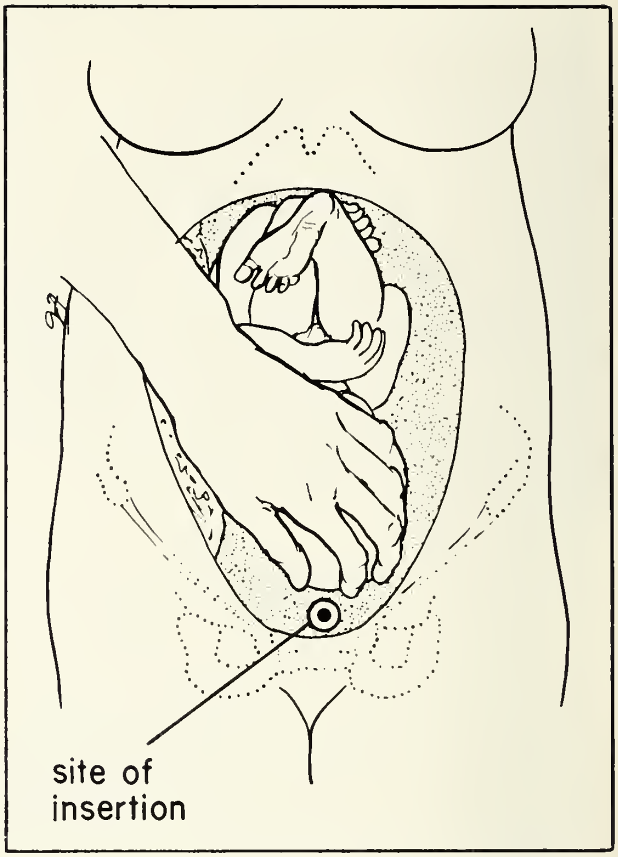
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Fig. 3 — In an unengaged vertex presentation the head is held up and the needle inserted just below the fingers.

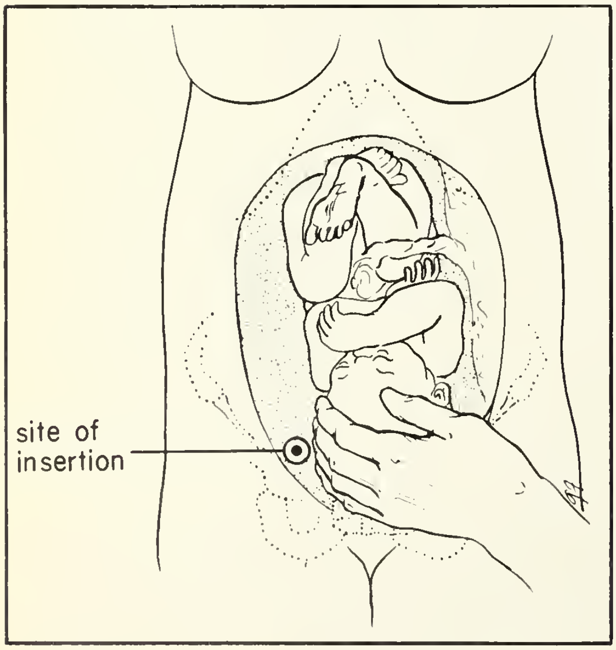
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Fig. 4 — In the engaged vertex presentation the head is displaced medially and held in position with insertion of the needle just below the fingers.

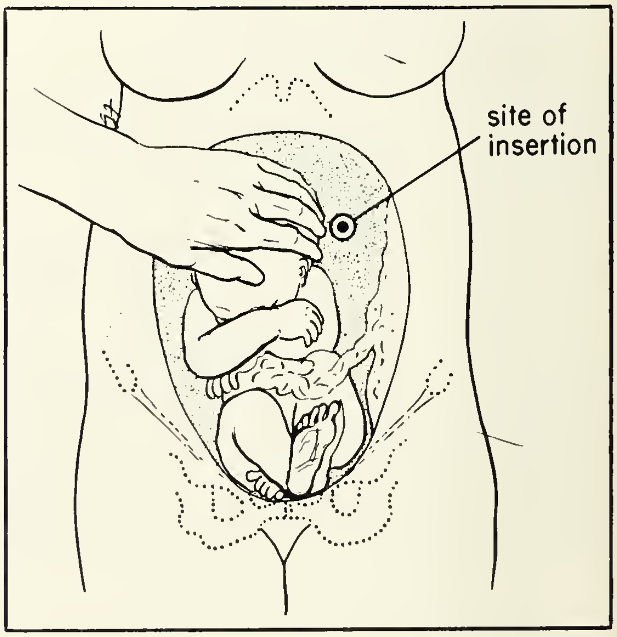
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Fig. 5 — Lateral displacement of the head in breech presentation.

contact with maternal skin. Aspiration should be gentle. It may be necessary to rotate the needle when fluid is not obtained. If resistance suggests fetal contact, slight withdrawal of the needle may permit aspiration of the fluid. If blood is obtained after partial withdrawal, the needle is usually in myometrium. Blood also may be aspirated from placenta or the fetus. Gross blood contamination usually invalidates the analysis of the fluid and a clean needle should be used in a new area. With experience the operator will know when the needle has reached the amniotic cavity. Slight blood contamination can be cleared with centrifugation.

APPLICATIONS

Rh Sensitized Mothers

The minimal level of maternal antibodies indicating amniocentesis depends on the experience and methods of the reporting laboratory. At present there is controversy about the antibody level which warrants this procedure. Most investigators recommend an Indirect Coombs of 1:16 or higher as a valid criterion.[2] In over 900 patients, we observed only one severely affected newborn with a level as low as 1:16. Levels of 1:32 or more seem more appropriate. With a previous perinatal death from erythroblastosis or a very high or abrupt rise of Rh antibody titers during early pregnancy, amniocentesis should be performed as early as 20-22 weeks gestation. Any of these conditions may also indicate prenatal transfusion which can be performed as early as 20-22 weeks gestation.[3] Otherwise the initial amniocentesis may be performed at 26-28 weeks gestation.

Timing of subsequent amniocenteses depends on the initial results, previous history, fetal activity, and changes in maternal antibodies. Optical densities suggesting severe disease, a previous erythroblastotic perinatal death, and an abrupt rise in antibody titers require shorter intervals between taps (7-10 days). Decreased fetal activity indicates immediate testing of the fluid. If these conditions are absent, repeat amniocentesis may be deferred for 2-3 weeks.[4]

Amniography

After withdrawal of 25-50 cc. of amniotic fluid, an equal amount of contrast material is injected. A 50 per cent solution of diatrizoate sodium* or a 60 per cent solution of diatrizoate meglumine** may be used. Intermittent aspirations confirm that the radio-opaque solution is being injected into the amniotic cavity. Sensitivity to the dye is tested prior to the procedure.

Amniography may localize the placenta. Anteroposterior and lateral X-rays taken within 30 minutes after injection of contrast material increase the accuracy of soft tissue placentography (**Fig. 6**). Similarly, amniography can be used to confirm soft tissue fetal anomalies (**Fig. 7**).

Films taken 3-4 hours after instillation of contrast material should outline small bowel when the fetus is alive. Absence of a small bowel pattern is presumptive evidence of fetal death. Contrast material may remain in the fetal colon for several weeks and after fetal death. The bowel outline serves as a guide for locating the fetal peritoneal cavity during intrauterine transfusions (**Fig. 8**).

Introduction of labor or abortion

Amniocentesis may be used to induce abortion or to induce labor after fetal death. One hundred and fifty to two hundred cc. of amniotic fluid is aspirated through a 16-18-gauge needle and replaced with an equal or larger amount of 20 per cent saline solution. A short plastic tube connects the needle to a 3-way stopcock. Another tube is connected from the stopcock to a sterile pan for disposal of the amniotic fluid first and later introduction into the container of the sterile saline

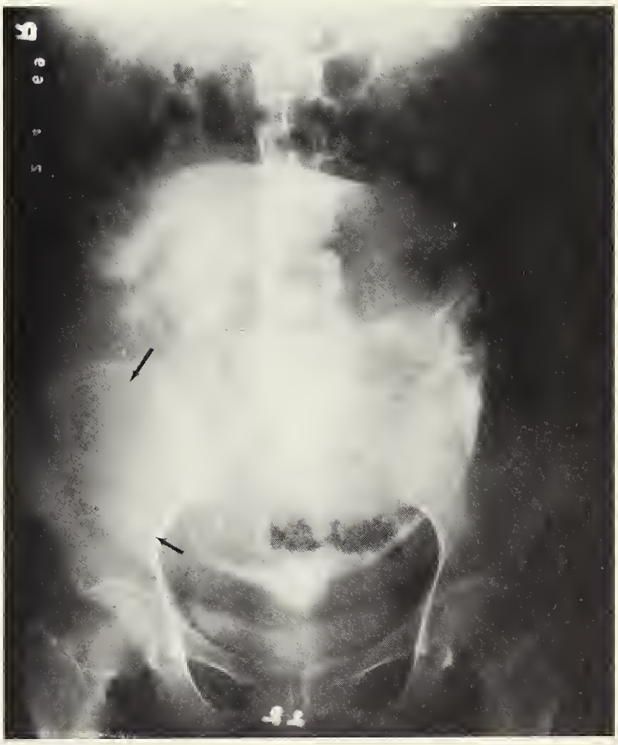

Fig. 6 — Amniogram demonstrating the presence of the placenta (arrows) and fetal soft tissue.

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* Hypaque sodium 50% solution — Winthrop Laboratory

** Renographin 60 — Squibb Laboratory

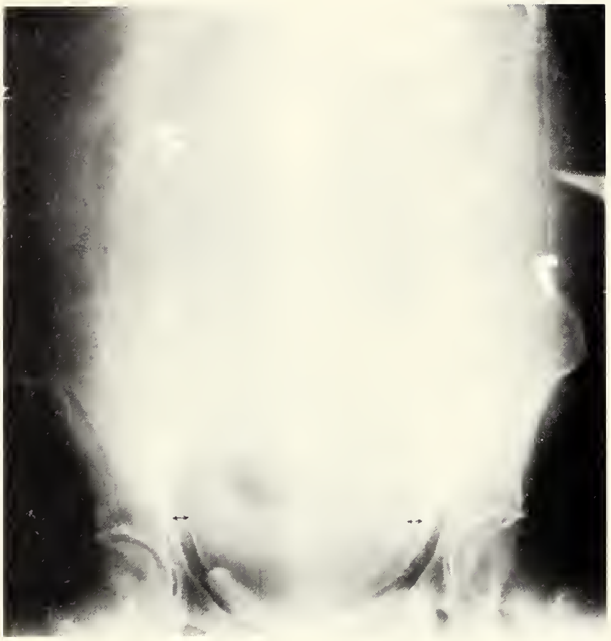

Fig. 7 — Amniogram of a hydropic fetus.

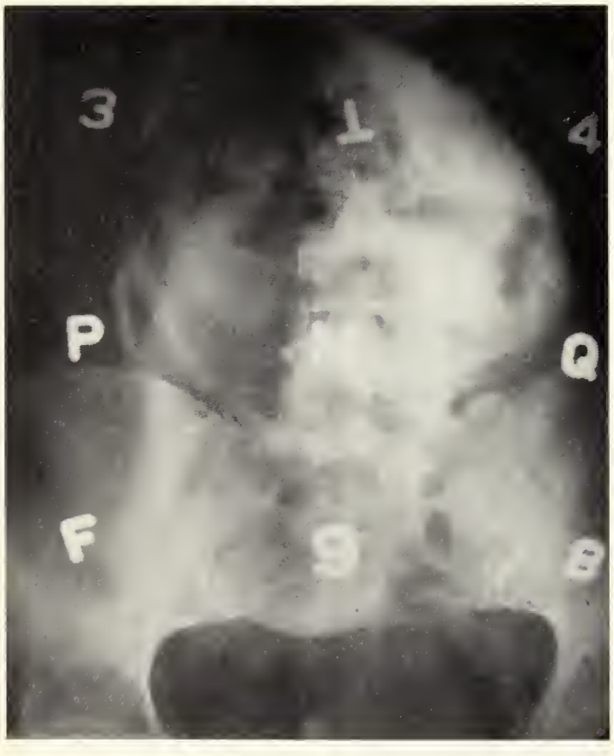

Fig. 8 — The stomach and small bowel outlined shortly after instillation of opaque material into the amniotic fluid.

solution. Frequent aspirations assure instillation of the saline into the amniotic cavity. Uterine contractions usually start within 24 hours. If not, the procedure can be repeated or augmented with oxytocin.

Frequent measurements of blood pressure and pulse during and after the procedure are indicated. Changes in maternal vital signs and/or aspiration of blood indicate immediate cessation of the saline injection. When blood is aspirated, the needle may be repositioned. Intravascular hypertonic saline may be lethal. Cardiac disease, toxemia, and hypertension contraindicate the injection of saline. Others have used hypertonic glucose solutions.

Determination of fetal maturity

Fetal maturity may be determined by the same technic used for the diagnosis of erythroblastosis. In the absence of erythroblastosis fetalis, elevation of the optical density of amniotic fluid at 450 mu disappears at approximately 36 weeks gestation. Prematurity should not be a survival factor beyond this point.[5]

Two other methods used to establish fetal maturity are the determination of creatinine in the amniotic fluid or the use of nile blue sulfate to stain cytoplasmic lipid in desquamated fetal cells.[6]

Determination of fetal sex and karyotype

A direct smear from the sediment of amniotic fluid stained with one per cent aqueous solution of Cresyl Violet Acetate is used to determine sex (Fisher # C-584). Presence of one or more sex chromatin or Barr bodies indicate a female fetus.[7] Curiosity about sex identification does not justify amniocentesis. However, determination of fetal sex may be of value in the detection of sex-linked anomalies. Amniotic cells culture may be of value in the early detection of fetal chromosomal aberrations.

MATERIAL

A total of 3,000 amniocenteses have been performed since early 1962. Nine hundred and twenty-five Rh negative sensitized patients have been submitted to amniocentesis and 2,534 samples obtained. The average number of amniocenteses have been three to five per patient. In this group, 160 patients received intrauterine transfusions which required amniography prior to the first transfusion. Eleven others had amniography for confirmation of fetal death. Induction of labor in the presence of fetal death using hypertonic saline was performed in 20. Four hundred and sixty-six amniocenteses were performed to determine fetal maturity.

COMPLICATIONS

Perforation of the placenta resulting in transfusion with fetal blood is always a potential danger. The effects of this accident on maternal sensitization is still controversial. It has been reported that feto-maternal transfusion following amniocentesis occurs in 11.2 per cent. Blood may be aspirated from the fetus. Thus, the presence of fetal blood does not necessarily indicate a placental puncture. In our series, 69 samples were contaminated with maternal or fetal blood.

Amnionitis is another risk. Two patients developed chills, fever and uterine irritability 7 days after amniocentesis. Treatment consisted of antibiotics and immediate delivery. Both infants survived.

Premature spontaneous labor occurred in another after leakage of amniotic fluid for two weeks following amniocentesis performed at 20 weeks gestation. Intrauterine deaths occurred after difficult amniocentesis in two severely sensitized mothers. Only blood had been obtained during repeated attempts. The cause of these fetal deaths is uncertain.

Another newborn showed scratch marks on a thigh without other signs of trauma. In one case, the injection of hypertonic saline had to be discontinued after 50 cc. of the solution had been injected because of sudden tachycardia and apprehension. Only one patient showed sensitivity to the opaque material used for amniography.

Complications should be rare with careful selection of patients and rigid application of the technic described.

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IN APPRECIATION

The author wishes to express his appreciation to Dr. Tommy N. Evans for the review and advice in this paper.

The Viewbox

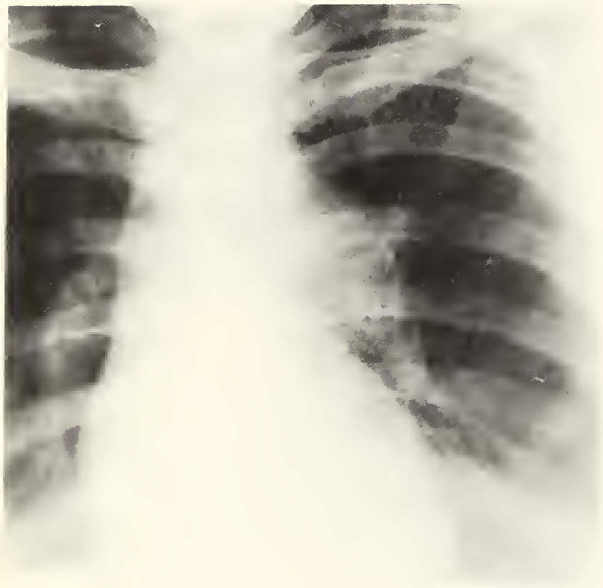

Fig. A

BY RAYMOND S. KURTZMAN, M.D.
ASSOCIATE SCIENTIFIC EDITOR

DIAGNOSIS:

PULMONARY VALVE STENOSIS (with post-stenotic dilatation of the pulmonary artery).

X-RAY FINDINGS:

The significant feature in the chest roentgenogram is enlargement of the left hilus, caused by dilatation of the left pulmonary artery. All the vessels in the left lung are slightly larger than those on the right, (**Figure A**). This is confirmed in the pulmonary angiogram, (**Figure B**).

DISCUSSION:

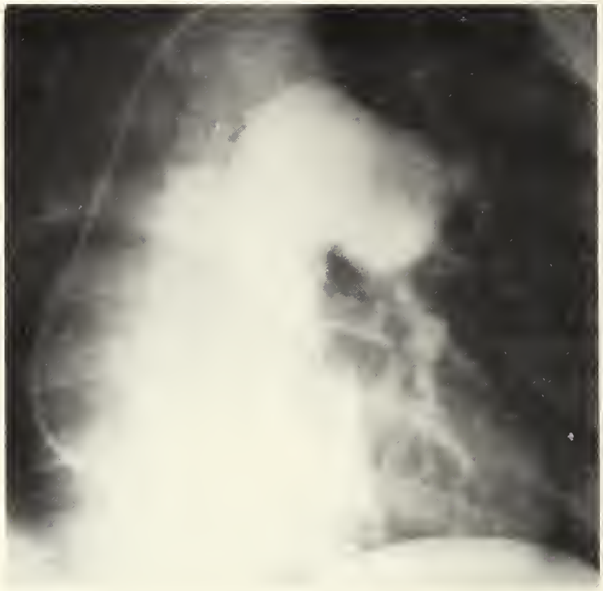

Fig. B

Stenosis of the pulmonary valve is almost invariably a congenital lesion, being acquired only rarely in, for example, the carcinoid syndrome. Symptomatic pulmonary stenosis in infancy frequently produces gross cardiomegaly. In adults, the lesion is less severe but produces radiologic changes which are a reflection of abnormal hemodynamics. Post-stenotic dilation is the result of a breakdown of normal streamline bloodflow, with stresses applied laterally to the walls of the arteries. The left pulmonary artery is a direct linear continuation of the main pulmonary artery which itself is in line with the flow of blood from the right ventricle. The right pulmonary artery branches from the main at about 90° and is longer than the left, allowing the abnormal stresses to be dissipated before the right pulmonary artery emerges from the heart shadow. This accounts for the characteristic discrepancy in size between the two pulmonary arteries. For the same reasons, fluoroscopic examination of the chest shows vigorous pulsations of the left pulmonary artery, with barely visible or no pulsations of the right. These findings are highly specific when they are present and the enlargement of the hilus is recognized as arterial and not the result of enlarged nodes.

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Treatment with Thioridazine Of Emotionally Disturbed Children In a Day Hospital

BY PEDRO A. OJEDA, M.D.
LANSING

From its establishment in 1965, the Ingham County Children's Psychiatric Day Hospital* has provided intensive treatment of emotionally disturbed children. Since the children seen here are of grade school age and educable, the specific aim of the program is to return the child to a regular school classroom as soon as possible. To accomplish this goal, the staff at the school may employ one or more modalities, including psychotherapy, milieu therapy and chemotherapy.

Initially, the staff psychiatrists had disagreed on the use of chemotherapy in the overall treatment program, largely because of their reliance on psychotherapy and their unfamiliarity with, or reluctance to accept, drugs. However, the acutely agitated state of many newly admitted patients necessitated the administration of tranquilizers, albeit reluctantly. This state of mind persisted until it was observed that the use of phenothiazines appeared to facilitate and to enhance the psychotherapy. This became especially evident in children with childhood psychoses or minimal brain damage and encouraged us to undertake the controlled study reported here, one designed to determine the usefulness of drug therapy on an objective basis. For this purpose, an active drug and placebo were administered separately on a double-blind and random basis, all other therapies being equally distributed.

METHOD AND MATERIAL

The children included in the study were those accepted at the hospital after referral by a parent or parent substitute, pediatrician, teacher, social welfare agency or court. A complete physical and neurological examination, an electroencephalogram and a complete blood count, urinalysis and liver function tests were performed in each child. Psychiatric screening consisted of a social history, psychological testing and interview by the child psychiatrist. All of the children were examined by speech, hearing and reading specialists, and some, by special education teachers, occupational and recreational personnel.

DURING THE COURSE of treatment, each child appeared at the hospital every weekday and received therapy to a total of about 38 hours per week. This included psychotherapy, educational, occupational, and recreational therapy. At all other times, the child was at home drawing upon parents, peers and other usual sources of psychological support. Where indicated, parents also participated actively in the program.

Presenting symptoms included hyperactivity, aggressiveness, anxiety, negativism, emotional immaturity, rage outbursts, school maladjustment and learning difficulties. Predominant diagnosis was childhood schizophrenia in 21 and minimal brain damage in 8 (Table I), with neurosis and transient situational reactions in 6.

TABLE I
RESULTS OF TREATMENT WITH THIORIDAZINE AND PLACEBO

	Thioridazine				Placebo			
Diagnosis	+++*	++	+	0	+++	++	+	0
Childhood Schizophrenia	3	4	8	0	1	1	2	2
Minimal Brain Damage Syndrome	1	1	1	0	0	0	1	4
Other +	1	1	0	0	1	1	1	1
Totals	5	6	9	0	2	2	4	7

*+++ = outstanding improvement; ++ = marked improvement; + = moderate improvement. 0 = no improvement
+ Including neuroses and transient situational reactions.

---

* Lansing, Michigan

The author is former director of the Ingham County Children's Psychiatric Day Hospital in Lansing. He is now in private practice in Lansing.

TABLE II
RESULTS OF DIAGNOSIS

Diagnosis	Childhood Schizophrenia		Brain Damage		Other**		Totals	
Result*	Drug T+	Drug P+	Drug T	Drug P	Drug T	Drug P	Drug T	Drug P
0	0	2	0	4	0	1	0	7
1	8	2	1	1	0	1	9	4
2	4	1	1	0	1	1	6	2
3	3	1	1	0	1	1	5	2
Total	15	6	3	5	2	4	20	15

* See text for description of results
+ Drug T = Thioridazine; Drug P = Placebo
** Including neuroses and transient situational reactions

The series consisted of 35 children (7 girls and 28 boys), aged 6 to 12 years, with the majority exhibiting abnormal electroencephalograms and varying degrees of central nervous system deficits, including minor speech problems, receptive aphasia, and slight to gross visual-motor coordination problems.

THE ACTIVE DRUG selected for this study was thioridazine,* an agent which has been found highly effective in the management of behavior disorders in children.[1,5,6] Its use has been marked by a virtual absence of Parkinsonism and the dystonic reactions which have limited the usefulness of other phenothiazines, especially in the treatment of children. The drug was provided in a liquid form** and administered in a fruit juice, as was the liquid placebo, identical in appearance to the concentrate.

Dosage was titrated according to the needs of each patient and ranged from 100-400 mg per day (average 250 mg) in children with childhood schizophrenia, from 100-250 mg (average 200 mg) per day in those with minimal brain damage and from 50-150 mg (average 100 mg) per day in the others. This was given in divided aliquots 3-4 times daily, with at least two of the doses being administered in the hospital. Adherence to drug ingestion was checked by the nurse supervisor and by the parents. Duration of treatment averaged 21 weeks.

Criteria for improvement included diminution of the presenting target symptoms, relationship to parents and/or hospital adjustment and degree of advancement to half-way or regular school attendance. These were rated and scored as +++ = outstanding improvement; ++ = marked improvement; + = moderate improvement; 0 = no change and − = worsening.

RESULTS

These are shown in **Table II.** Of the four girls and 16 boys receiving thioridazine, all improved. Outstanding improvement was obtained in five, marked improvement in six and moderate improvement in nine. Of the 15 children (three girls and 12 boys) receiving placebo, outstanding improvement was obtained in two, marked improvement in two and moderate improvement in four. The remaining seven, almost half of the total, failed to demonstrate any improvement. Comparing the improvement scores for the two agents, thioridazine was found to be significantly superior to placebo ($t = 2.66$; $p < 0.01$).

In the largest group, childhood schizophrenia, thioridazine produced outstanding improvement in three patients, marked improvement in four and moderate improvement in eight. Placebo produced outstanding improvement in one patient, marked improvement in one, moderate improvement in two and no improvement in one.

Improvement was characterized by a decrease in aggressive behavior, rage outbursts and anxiety and was accompanied frequently by increased attention span leading to better adjustment in the school, home and hospital environment. As a rule, initial improvement was noted within two to three weeks in most of the patients and was maintained at this level throughout the entire treatment period.

An objective measure of improvement was school attendance. Of the 20 children receiving thioridazine, 16 were able to return to their regular classrooms or were promoted to half-way schools. The other four were still attending the hospital school at the conclusion of the study. Of the 15 children receiving placebo, three were able to attend regular classrooms, four the half-way schools, and the remaining eight were still attending the hospital school.

No serious side effects or abnormal laboratory values were observed during the study. Some of the children experienced drowsiness to a minor degree during the first three or four days of treatment with thioridazine, but this was transient and did not require a decrease in dosage or discontinuation of the drug. Three children exhibited an initial weight gain but this returned to normal after adjustment of diet. In two other children, the weight gain persisted and the drug was withdrawn.

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* Mellaril, Sandoz Pharmaceuticals
** Mellaril Concentrate, 30 mg/ml thioridazine

DISCUSSION

The value of the phenothiazines in the treatment of mental disorders has been more than amply documented. Their usefulness when given in conjunction with psychotherapy has also been well-established, with the comprehensive study by the Veterans Administration being especially commendable. In this,[3] chronic schizophrenic patients received thioridazine and/or psychotherapy and responded best to the combination of thioridazine and group psychotherapy, an improvement statistically superior to that obtained with psychotherapy alone. Reported at the 1967 meeting of the American Psychiatric Association was a study in which thioridazine or placebo was administered for two years to patients receiving intensive psychotherapy from a psychoanalyst or psychoanalytically-oriented therapist. The investigators demonstrated "how important the combination of thioridazine, psychotherapy, and milieu therapy was, and how relatively unimpressive were the results in the patients who received the same type of psychotherapy and milieu therapy without concomitant thioridazine treatment."[4]

In this study, all of the 20 children treated with thioridazine improved as compared with eight of 15 receiving placebo. Socioeconomic background and a greater degree of family interest and support may have contributed to the improvement observed in the eight children on placebo. The greater improvement in children given thioridazine must be attributed to the drug since all children in both groups had received psychotherapy and milieu therapy. Specifically, the children who received thoridazine showed more rapid improvement of aggressive and disruptive behavior, more rapid adjustment to the hospital routine and better rapport with the therapist.

The capacity of thioridazine to induce tranquilization without excessive drowsiness or a dulling effect was instrumental in generating increased attention span and served to facilitate the learning process. The absence of extrapyramidal symptoms was equally valuable for these can cause body image aberrations and disrupt motor control.[2] There is no doubt that excellent toleration was a contributing factor to the therapeutic effect obtained with thioridazine. This is an important consideration in all patients with emotional disorders, but especially so in children.

SUMMARY AND CONCLUSIONS

A study, utilizing a placebo as control, has demonstrated that thioridazine is an effective agent in the treatment of emotionally disturbed children in a day hospital. Based on the results obtained in this study, children exhibiting hyperactivity, aggressiveness, anxiety, negativism, emotional immaturity, rage outbursts, and school maladjustment with learning difficulties may be considered logical candidates for treatment of thioridazine. Its usefulness was enhanced by the relative freedom from side effects.

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Monthly Surveillance Report
Cases of Certain Diseases Reported To the Michigan Department of Public Health For the Four-Week Period Ending January 30, 1970

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

	1970 THIS 4-WEEK PERIOD	1969 SAME 4-WEEK PERIOD	1970 TOTAL TO ABOVE DATE	1969 TOTAL SAME DATE	PROVISIONAL TOTAL FOR 1969
Rubella	317	166	317	166	4307
Measles	40	12	40	12	401
Whooping Cough	7	4	7	4	192
Diphtheria	—	—	—	—	—
Mumps	502	366	502	366	5215
Scarlet Fever & Strep Sore Throat	1210	918	1210	918	9763
Tetanus	—	—	—	—	6
Poliomyelitis (Paralytic)	—	—	—	—	—
Hepatitis	423	213	423	213	3361
Salmonellosis (Other than S. typhi)	51	37	51	37	539
Typhoid Fever (S. typhi)	1	—	1	—	6
Shigellosis	17	34	17	34	300
Aseptic Meningitis	5	7	5	7	181
Encephaltis	8	10	8	10	119
Meningococcic Meningitis	10	22	10	22	115
H. Influenzal Meningitis	8	2	8	2	55

	1970 THIS 5-WEEK PERIOD	1969 SAME 5-WEEK PERIOD	1970 TOTAL TO ABOVE DATE	1969 TOTAL SAME DATE	PROVISIONAL TOTAL FOR 1969
Tuberculosis	235	217	229	210	2108
Syphilis	324	437	324	437	4021
Gonorrhea	2038	1609	2038	1609	19,194

R. Gerald Rice, M.D., Acting Director
Michigan Department of Public Health

Silicone Rubber Prostheses Replace Inadequate Joints

The following article is reprinted from the John A. Hartford Foundation's Bulletin of December, 1969, describing some of the current developments in medical research sponsored by the foundation.

Significant contributions are being made by investigators at Blodgett Memorial Hospital, Grand Rapids, Mich., to the development of prosthetic implants for replacing inadequate joints and to their clinical application in orthopedic practice.

The project was initiated several years ago with the design and laboratory testing of a mushroom-shaped, silicone rubber implant for cushioning the ends of long bones in human amputees. Following a series of clinical uses at this hospital, during which time surgical techniques were also improved, the device was released for field testing and evaluation. This is now being done at 16 other hospitals and clinics. More than 100 such implants are functioning effectively and show no signs of deterioration after 5 years. On the basis of continuing review of patients by clinical evaluation and X-ray examination, it is reported that this technique offers many advantages over standard methods of amputation surgery.

A smaller version of the mushroom device is also being used to cap amputated arm bones in children. It shows promise as a control mechanism to prevent the growing bone from penetrating the stump tissue, as is frequently a problem in juvenile patients.

Much broader application of the silicone rubber prostheses, and similar clinical success, is being found in replacement of arthritic or traumatically-injured joints of the hand. This procedure is now becoming well established and is being applied by more than 150 research teams in field trials in this country and abroad. In all instances, collaborating surgeons follow methods developed by the principal investigator and report results in a standard manner for computer evaluation.

Development work is going forward on 17 types of implants, mainly for upper-extremity joints including elbow and shoulder. Also, lower-extremity prostheses for toes, knees and hips are in early design stages. (Principal Investigator: Alfred B. Swanson, M.D.)

Authors Note: The two really new things in treating asthma — namely the "team approach," with the patient in an intensive care environment, and the use of assisted respiration — are both so valuable that we feel they should be published. We have purposely kept this article short so that all will read it. The references included are the key articles which will provide the details which one unfamiliar with the procedures might need. This procedure is being used at the University of Michigan Medical Center, and more recently at Wayne County General Hospital.

Management Of the Moribund Asthmatic Patient

BY ROBERT G. LOVELL, M.D.
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PORTLAND, ME.

It is worthwhile to consider the new developments in the medical care of the critically ill patient with bronchial asthma. In spite of our enlightenment regarding the need for vigorous and appropriate treatment of the patient in status asthmaticus, the death rate from asthma especially in children has been increasing.[1,2,6]

One of the new developments in the care of the asthmatic is conceptual, and calls for management by a team of physicians; the other innovation is the wide acceptance of assisted respiration in the moribund asthmatic.[8,9,10]

Space prevents reiterating the measures which should be taken to prevent a patient from going into a severe asthma bout. Environmental control, careful use of bronchodilators, expectorants, antibiotics where indicated, and hydration are all important. Hyposensitization for specific allergy is a time-honored means for bringing inhalant sensitive patients under good control.

WE SHOULD LIKE to point out the procedure which has been evolved, and which shows considerable promise in restoring the moribund asthmatic to safety. We all are concerned about the frightened, exhausted, dyspneic patient whose asthma fails to respond favorably to the injection of epinephrine. Such patients should be hospitalized, and preferably placed in an intensive care unit. Intravenous fluids, (5 per cent glucose in water), one to three liters per day should be started. Amniophylline (one to two grams per 24 hours in adults), and antibiotics should be included in the infusion. Susphrene,® an aqueous suspension of epinephrine 1:200 should be given up to 0.3 ml every 6 hours. We prefer a tent with cold steam for children, oxygen in the presence of cyanosis. Intermittent positive pressure three to four times daily, with the Bird or Bennett machine, using 6 drops of Isuprel® 1:200 in 4 ml of saline, will help to thin the thick bronchial secretions. Sedation, in individual cases, may be beneficial, using barbiturates, Sparine,® or hydroxazine (Atarax®).

Laboratory studies should include serum sodium, CO_2, potassium and chloride; a complete blood count and a chest X-ray. The arterial pCO_2, the pH, and pO_2 are also helpful in case the patient fails to respond favorably.

As the patient's condition deteriorates, we advocate 0.2 - 0.3 ml of epinephrine HCl at 15 minute intervals, maximum of three doses. This is followed by intravenous sodium bicarbonate (44-88 mEq. infused within 20 minutes). Corticosteroids, such as Solu-Cortef® 100-200 mgm may be started intravenously. We give up to 1000 mgm in 24 hours to our most severely-ill patients.

IF THE PATIENT is unresponsive to these measures, his condition is critical, and he should be moved to an operating room or to a fully equipped assisted respiration area in an intensive care unit.[4] A team of physicians, composed of an anesthesiologist, a thoracic surgeon or an otolaryngologist as well as the internist or pediatrician trained in allergy has the best chance of saving the patient.

Doctor Lovell is associate professor of internal medicine at the University of Michigan School of Medicine. Doctor Lovell and Doctor Preuss are on the Staff of St. Joseph Mercy Hospital in Ann Arbor and Doctor White is associated with Portland Clinic, Portland, Me.

Indication for assisted ventilation is seen where there is progressive abnormality in the blood gas values. The pCO_2 is our most helpful value When it rises above 55 mm of mercury, the team should be assembled. Actual introduction of assisted respiration is determined by the presence of such physical findings as cyanosis, change in blood pressure, lethargy, confusion, air hunger, exhaustion, or a "silent chest."

With induction of assisted ventilation, using bag breathing by the anesthesiologist, the Bird or Bennett machine or the controlled respirator (Emerson or Morsch), sedation should be used to allay anxiety, to promote amnesia especially in children, and to afford muscle paralysis. We use intravenous 0.2 per cent succinyl choline for paralysis.[7,8,9,10]

ENDOTRACHIAL INTUBATION SHOULD be tried before tracheostomy. Bronchoscopy in the hands of a skilled operator may be beneficial for removing retained secretions. Inspissated mucus may be suctioned using sterile technique, and repeated bronchial lavage with warm normal saline may be very helpful in removing secretions.

Monitoring of the patient's general condition, his vital signs and urinary output are necessary. The blood gases should be obtained repeatedly at one to four hour intervals. Prolonged use of the assisted ventilation machine may be needed. Avoidance of prolonged high concentration of oxygen therapy is important.[5] We try to keep the pO_2 between 80-140 mm of mercury. Decreasing arterial pO_2 below 80 offers a grave prognosis. Serum electrolytes should be followed as in any acidotic state, with attention to the potassium.

Modes of death are varied. Sudden death may occur from cardiac arrhythmia, respiratory failure, or iatrogenic miscalculation.[3] Protracted causes include infection, drug intoxication (aminophylline, epinephrine or sedative), cardiac failure, adrenal failure, pulmonary hemorrhage or hyaline membrane formation from prolonged high concentration of oxygen therapy.[4]

It is important to keep checking the basic program. The tendency, surprisingly, is to do too little as death appears imminent.

SUMMARY

Management of the moribund asthmatic patient demands that he be in the hospital in an intensive care unit where assisted respiration can be provided. The modern approach to therapy involves a team of physicians, including an anesthesiologist, a thoracic surgeon (or otolaryngologist) as well as the allergist-internist or pediatrician, who retains control of the program. Each physician can contribute his special skill to the management.

It is hoped that greater attention to the details of proper care will help to reverse what appears to be an increase in the death rate from asthma, especially in children.

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AN ETIOLOGIC AND CLINICAL STUDY

Viral Infections In a Large Urban Hospital

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INTRODUCTION

Recent developments in methodology have enabled us to obtain more rapid and accurate diagnosis of viral diseases. Many viruses, however, especially those isolated in the past 15 years, have not been clearly associated with a specific clinical syndrome. In fact, one whole group, the echoviruses, were placed in the "human orphan" category because their relationship to human disease was unknown when they were originally isolated. Today, virologists are finding that more and more human viruses can be related to disease, but that one virus is often associated with a variety of clinical syndromes. The physician is therefore often unable to diagnose viral infections without ancillary laboratory investigations. Studies of the type reported here emphasize the fact that only through a close liaison between the physician and the virus diagnostic laboratory can definitive diagnosis become a reality.

MATERIALS AND METHODS:

Clinical Material

Between July, 1962 and July, 1967 the authors made a clinical and virologic study of 720 selected patients admitted to the Communicable Disease Division of Herman Kiefer Hospital in Detroit, Michigan, an isolation facility available to all practicing physicians in the tri-county area of Wayne, Oakland, and Macomb. Eighty percent of the patients admitted were under 10 years of age and required hospitalization because of common childhood diseases with complications.

Virus Isolation Procedures

Fecal specimens collected within the first few days post-onset and free of any preservatives were shipped immediately to the Virology Laboratory, Michigan Department of Public Health, where they were stored at -20 C until tested. At least two consecutive fecal specimens were submitted from each patient whenever possible, since virus may be present in only a portion of the stools passed. Representative portions of fecal material were transferred to sterile swabs. The swab was then expressed into three to five ml of Hanks' balanced salt solution containing antibiotics. The suspension, clarified by centrifugation, was inoculated into HEp#2 and Rhesus monkey kidney tubes and the tubes observed daily for cytopathic effect (CPE). Specimens were considered negative only after two transfers or 21 days of total observation time. Baby Swiss white mice were also inoculated intracranially for isolation of Coxsackie A viruses.

Throat swabs for rubellavirus isolation were collected within the first three days of illness and expressed into tubes of tryptose phosphate broth containing 0.5% gelatin. Specimens were iced or frozen until processed. African Green monkey kidney cells, inoculated with 0.5 ml of the broth suspension, were challenged several days later with 100 tissue culture doses of Coxsackie A9 or Echovirus 11 to detect the presence of an interfering agent. Interfering agents were considered to be "probable rubella" when culture remained normal for at least two days after control tubes showed 75-100% degeneration. Occasionally, two transfers were required before complete interference was obtained.

Identification of Enterovirus Isolates

All fecal isolates were first grouped according to their effect on Rhesus and HEp#2 cells. Our

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experience with field and laboratory strains of enteroviruses, and similar experience of others[1] indicate that the HEp#2 line is sensitive to the three types of poliovirus and all six Coxsackie B viruses, but consistently resistant to all Echo and Coxsackie A viruses. Through the combined application of this host cell infectivity spectrum and the use of serum combination pools[2], preliminary identification of the enteroviruses was greatly simplified.

Acid production and type of CPE in HEp#2 also aided in the early recognition of adenoviruses.

All enterovirus isolates were typed by tissue

TABLE 1
SUMMARY OF LABORATORY CONFIRMED CASES OF VIRUS DISEASE OVER A 5-YEAR PERIOD

Virus Associated with Illness	No. Patients
Adenovirus	16
Coxsackievirus	27
Echovirus	35
Herpes simplex	24
Influenza	18
Measles	17
Mumps	69
Parainfluenza	2
Poliovirus	14
Respiratory Syncytial Virus (RSV)	7
Rubellavirus	19
Unidentified	2
Total	250

TABLE 2
CLINICAL DIAGNOSIS ASSOCIATED WITH ENTEROVIRAL INFECTIONS

Virus	Clinical Diagnosis	No. Patients	Total
ECHOVIRUS			35
Type 4	Aseptic Meningitis	1	
	Rash	1	2
6	Aseptic Meningitis	8	8
7	Aseptic Meningitis	1	1
9	Aseptic Meningitis	15	
	Rash	2	
	Hepatitis	1	18
11	Aseptic Meningitis	2	
	Vesicular Stomatitis	1	
	Pertussis	1	4
14	Stomatitis, Stevens-Johnson syndrome	1	1
22	Vesicular Rash & Stomatitis	1	1
COXSACKIE VIRUS			27
Type A-4, 6, 16	Vesicular Rash	5	5
A-9	Aseptic Meningitis	6	
	Rash, non-vesicular	1	
	Pertussis	2	9
B-1	Aseptic Meningitis	2	
	Pleurodynia	1	3
B-2	Aseptic Meningitis	2	2
B-3	Aseptic Meningitis	1	1
B-4	Aseptic Meningitis	2	2
B-5	Aseptic Meningitis	5	5
POLIOVIRUS			14
Type 1	Paralysis	5	
	Aseptic Meningitis	1	6
2	Paralysis	1	1
3	Paralysis	6	
	Aseptic Meningitis	1	7

TABLE 3
CLINICAL DIAGNOSIS ASSOCIATED WITH NON-ENTEROVIRAL INFECTIONS

Virus	Clinical Diagnosis	No. Patients	Total
MUMPS	Mumps meningoencephalitis	33	
	Aseptic meningitis	24	
	Parotitis with or without orchitis	6	
	Others	6	69
MEASLES	Measles with or without complications	16	
	Scarlatiniform rash and Jaundice	1	17
RUBELLAVIRUS	Clinical rubella	19	19
ADENOVIRUS	Rash and RI and other symptoms	7	
	Respiratory infection only	1	
	Other (see Table 6)	6	
	Stomatitis	2	16
HERPES SIMPLEX	Vesicular stomatitis	11	
	Meningoencephalitis	8	
	Febrile illness with:		
	Convulsion	3	
	Chicken pox	1	
	Hepatitis	1	24
INFLUENZA A	URI, Tracheobronchitis	5	
	Morbilliform rash with URI	3	
	Febrile illness with convulsion	1	9
INFLUENZA B	URI, Tracheobronchitis	6	
	Aseptic meningitis	2	
	Hepatitis	1	9
PARAINFLUENZA	Aseptic meningitis with URI	1	
	Morbilliform rash with URI	1	2
RSV (RESPIRATORY SYNCYTIAL VIRUS)	Pertussis	5	
	Measles with Bronchiolitis	1	
	Encephalitis	1	7
UNIDENTIFIED	Aseptic meningitis	2	2

culture or baby mouse neutralization tests using specific immune rabbit serum or immune mouse ascitic fluid[3] for certain of the Coxsackie viruses.

Several of the enteroviruses agglutinate human type "O" erythrocytes, the titer varying with virus type and temperature of incubation[4]. The hemagglutination test was therefore also used as a screening procedure in identification.

Serologic Tests

A fourfold increase in antibody titer between acute serum taken within the first week of illness and a convalescent serum taken two to three weeks later was considered diagnostic. In order to determine the etiologic significance of a virus isolate, the agent was tested with acute and convalescent sera of the patient yielding the virus for evidence of specific neutralizing antibody. Neutralization tests were performed in tissue culture or baby mice.

In the absence of virus isolation the serologic method of choice was the complement fixation test. The test procedure was essentially that of Schmidt and Lennette[5] except that the diluent consisted of 8.5 g of NaCl, 0.1 g $MgCl_2 \bullet H_20$ and 0.04 g $CaCl_2 \bullet 2H_20$ per liter. Primary incubation was carried out at 4 C for 18 hours.

Assay of rubella antibody was performed by the National Communicable Disease Center, Atlanta, Georgia, using the fluorescent antibody method[6]. Both the FA test and virus isolation were used to confirm rubellavirus infection.

RESULTS

Over the five-year study period, 1962-67, viral etiology was proven by either isolation and serologic response or by serologic response alone in 250 or 35% of the 720 cases examined (**Table 1**). A summary of virus type and associated disease is given in **Tables 2 and 3**. The most common clinical entity from which isolates were obtained was aseptic meningitis; this diagnosis was confirmed by CSF findings in 76 cases, of which 47 were caused by enteroviruses (**Table 2**), 24 by mumps, 2 by influenza B, 1 by parainfluenza, and 2 by unidentified agents (**Table 3**). In about 1/3 of the enteroviral meningitides, the polymorphonuclear leucocyte was the predominant cell in the CSF.

Twenty-seven of 35 echovirus infections produced meningitis. The other eight agents were associated with such diverse clinical diagnoses as hepatitis, suspected measles, chicken pox, Stevens-Johnson syndrome and suspected pertussis (**Table 4**).

TABLE 4
CLINICAL SUMMARY AND SEROLOGIC DATA ON CASES (OTHER THAN ASEPTIC MENINGITIS) WITH EVIDENCE OF ECHOVIRUS INFECTION

Clinical Diagnosis	Age	Sex	Neut. Titer[1]		Viral Agent	Isol.	Clinical Findings	Other Lab Data
			Serum #1	#2				
Viral Exanthema; Suspected Measles	10 Mo.	F	256	1024	E9	yes	Morbilliform, Rash, fever, No Koplik's spots	WBC = 6300, P = 43, L = 49 M = 3, E = 5 CF[2] neg. for measles
	19 Y	M	< 8	64	E9	yes	History of measles in the past, Fever, morbi., rash	WBC = 7600, P = 80, L = 13, E = 7 CF neg. for measles
Possible Chicken pox R/O Viral Exanthema	2 Y	M	64	256	E22	yes	Vesicular rash, secondary infection, stomatitis	WBC = 9050, P = 52, L = 40, M = 3, E = 1 CF neg. for H. simplex
Stevens-Johnson Syndrome	7 Y	F	< 8	16	E14	yes	High temp., severe stomatitis, dehydration req. I.V.	WBC = 12000, P = 83, L = 10, M = 4, E = 1, B = 2 CF neg. for H. simplex
Hepatitis Etiology (?)	13 Y	M	32	128	E9	no	Jaundice, tender liver, abdo. pain	WBC = 6550 Initial: BIL = 20.6 SGPT = 850 Later: BIL = 3.5 SGPT = 537
Suspected Pertussis	12 Mo.	F	< 8	32	E11	yes	Paroxysmal cough, vomiting, no history of exposure to pertussis	WBC = 25000, P = 44, L = 41, M = 3, E = 1
Vesicular Stomatitis	22 Mo.	F	< 8	64	E11	yes	Vesicular rash on face and mouth	WBC = 6600, P = 31, L = 61, M = 4, E = 4 CF neg. for H. simplex
Rash	28 Y	M	< 8	< 8[3]	E4	yes	Gastrointestinal upset	

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[1] Reciprocal of neutralization titer of acute and convalescent sera

[2] CF = Complement fixation

[3] Etiology not proven serologically

TABLE 5
CLINICAL SUMMARY AND SEROLOGIC DATA ON PATIENTS (OTHER THAN THOSE WITH ASEPTIC MENINGITIS) WHO HAD EVIDENCE OF COXSACKIEVIRUS INFECTION

Clinical Diagnosis	Age	Sex	Neut. Titer		Viral Agent	Isol.	Clinical Findings	Other Lab Data
			S1	S2				
Herpangina and Hand-Foot-Mouth Disease	3 Y	F	< 8	256	Cox A4	+	Pharyngitis with herpetiform stomatitis	WBC = 2950 P = 60, L = 26, E = 1, M = 8
	43 Y	M	16	128	Cox A16	+	Herpetiform stomatitis tonsillitis	WBC = 9000 P = 73, L = 24, E = 2 N-P culture neg.
	3½ Y	F	< 8	32	Cox A16	+	Vesicular lesion of mouth, hands and feet	
	10 Y	F	< 8	32	Cox A16	+	Vesicular lesion of mouth, hands and feet	
Atypical Rash	19 Y	M	< 8	16	Cox A9	+	Atypical rash, Morbilliform?	WBC = 7900 P = 80, L = 12, M = 1, E = 7
	9 Y	M	32	128	Cox A6	+	Atypical rash, scarlatiniform	WBC = 19300 P = 94, L = 4, E = 2
Pertussis	10 Mo.	F	< 8	32	Cox A9	+	Paroxysmal cough, vomiting, no immuniz., no history of contact with pertussis	WBC = 19600 P = 47, L = 50, M = 3 N-P culture neg. for B. pertussis
	10 Mo.	F	< 8	256	Cox A9	+	Paroxysmal cough, vomiting, no immuniz., no history of contact with pertussis	WBC = 17900 P = 70, L = 28, M = 2 N-P culture neg. for B. pertussis
Pleurodynia	19 Y	F	< 8	512	Cox B1	+	Stiff back and chest pain, CSF and chest X-ray neg.	WBC = 5150

THE COXSACKIEVIRUSES, like the echoviruses, were generally isolated from patients with aseptic meningitis (18 of 27) (**Table 2**). Of 13 Coxsackie B infections, it is noteworthy that pleurodynia was described in one case only, although this syndrome is commonly associated with the Coxsackie B viruses. Coxsackie B-5 infection was widespread throughout Michigan in 1961 and again in 1967, and most of the 38 other strains isolated statewide were associated with meningitis. One-fourth of the patients from which Coxsackie B-5 was isolated, however, had respiratory symptoms.

Several of the Coxsackie A viruses isolated from patients at Herman Kiefer Hospital were associated with atypical rash and hand-foot-mouth disease (**Table 5**). Type 16 has been commonly associated with epidemic hand-foot-mouth disease,[7] whereas types 4, 5 and 10 have caused only sporadic cases or small confined outbreaks.[8-10] During the spring and summer of 1966, an epidemic of A16 spread throughout the Detroit area, and type A16 was also isolated from various sections of Wayne County. The illness began with a faint reddish macule which in about 12 hours formed a reddish papule. After 24 hours, the lesions tended to vesiculate. Their distribution was limited chiefly to the plantar surface of the feet, palmar surface of the hands, the posterior pillars of the pharynx, the buttocks and mucous membrane. With the onset of the macular phase, there was mild listlessness which lasted about one day.

It is of interest that in Michigan the majority of the rashes caused by Coxsackieviruses are of vesicular nature, whereas those caused by echoviruses are chiefly morbilliform or scarlatiniform, rarely vesicular.

Influenza is usually associated solely with respiratory illness. In this series, however, three of the nine influenza A cases manifested a rash, whereas none of nine influenza B patients (**Table 3**) showed this sign.

ADENOVIRUSES, though also associated primarily with respiratory disease, produced extrarespiratory symptoms in most of the patients in this series (14 of 16), and in five cases produced no respiratory symptoms whatever (**Table 6**). It is of interest that both rash and gastrointestinal symptoms were often associated with the adenovirus infections (10 of 16 with skin or mouth rashes and five of 16 with gastrointestinal symptoms). On a statewide basis, 85 other adenovirus infections were diagnosed during the same five-year period. The frequency of rash and gastrointestinal symptoms were 26% and 25%, respectively. With the eventual eradication of measles through immunization, the adenoviruses could become one of the major causes of morbilliform rash in children. Previous reports also indicated that adenovirus can produce rash similar to that of rubella, with or without encephalitis[11]. When adenoviruses have been reported as causing gastrointestinal symptoms, they have been associated

TABLE 6
CLINICAL SUMMARY AND SEROLOGIC DATA ON PATIENTS WITH EVIDENCE OF ADENOVIRUS INFECTION

Clinical Diagnosis	Age	Sex	CF Titer[1]		Lab Data and Clinical Findings	Other Viral Studies
			S1	S2		
Viral Exanthema with Respiratory Infection, Suspected Measles	21 Mo.	M	< 8	64	URI, morbilliform rash WBC = 12,600, P = 73, L = 24, M = 3	Neg. for measles and enteroviruses
	6 Y	M	< 8	16	URI, measles rash, Koplik's spots, vomiting WBC = 4100, P = 62, L = 38	Neg. for measles and enteroviruses
	30 Mo.	F	16	64	URI, morbilliform rash WBC = 2500, P = 25, L = 75	Neg. for measles and enteroviruses
	20 Mo.	M	< 8	16	URI, morbilliform rash WBC = 6500, P = 71, L = 26, E = 3	Neg. for measles and enteroviruses
	5 Y	M	32	> 128	URI, cervical adenitis, morbilliform rash, fever WBC = 11,600, P = 71, E = 22, M = 5, E = 2	Neg. for measles and enteroviruses and RS virus
	3 Y	M	8	128	Tracheobronchitis, scarlatiniform rash, fever WBC = 11,900, P = 84, L = 6, M = 4, E = 6	Neg. for measles and enteroviruses
Herpetic Stomatitis	5 Y	M	< 8	32	No URI, vesicular lesions in mouth, vomiting, temp. 104-105° for 2 days. WBC = 16,450, P = 83, L = 15, M = 2	Neg. for H. simplex No evidence of enterovirus infection
	9 Y	M	< 8	32	No URI, vesicular lesions of mouth, skin rash, cervical adenitis. WBC = 9800, P = 79, L = 20, M = 1	Neg. for H. simplex and enteroviruses
Cervical Adenitis Etiology?	10 Y	M	< 8	32	URI, vomiting. WBC = 3,250, P = 50, L = 44, M = 6	Neg. for enteroviruses and influenza
Tracheobronchitis	3 Y	M	8	128	Cough, runny nose. WBC = 5700, P = 55, L = 43, M = 2	
Bronchiolitis with rash	5 Y	F	16	64	Acute resp. symptoms, morbi. rash. WBC = 4,100, P = 63, L = 36, M = 1	Neg. for measles, H. simplex and enteroviruses
Abdominal Pain Etiology? Cervical Adenitis	10 Y	M	8	64	URI, fever, stiff neck. WBC = 5,400	
Viral Encephalitis	3 Y	F	8	128	Morbi. rash, ataxia, vomiting. WBC = 9900, P = 74, L = 22, M = 0, E = 2 CSF count = 150, mostly lymphs.	Neg. for measles, mumps, H. simplex and enteroviruses.
	6 Y	M	32	128	No URI, Meningo-encephalitis vomiting, vesicular stomatitis CSF cell count = 327	Neg. for mumps, H. simplex, and enteroviruses
Parotitis	8 Y	M	8	32	No URI, parotitis. WBC = 23,050, P = 89, L = 11, Serum amylase = 13	Neg. for mumps
Parotitis and Cervical Adenitis	2 Y	M	8	128	URI, WBC = 6000, P = 47, L = 51, M = 2 Amylase = 121	Adenovirus isolated

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[1] Reciprocal of titer.

chiefly with types 3 and 7, the two predominant types encountered in Michigan[12, 13]. Most patients in this study from whom adenovirus was isolated had severe bronchiolitis requiring oxygen and intensive therapy.

Respiratory syncytial virus was proven to be the etiologic agent in five of eight children with pertussis-like syndrome (Table 7). This virus reportedly accounts for about one-fifth of the severe lower respiratory infections and bronchiolitis in children less than four years old[14, 15]; that this virus causes severe respiratory infections in Michigan is borne out by results both of this study and statewide data. Table seven indicates that Coxsackie A9 and echovirus 11 may also cause a similar syndrome.

DISCUSSION

Generally, practicing physicians do not request viral diagnostic tests because of the time lag between submission of specimens and receipt of the laboratory report. True, the diagnosis is often in retrospect; however, there are occasions in which the diagnosis is sufficiently prompt to be of immediate and practical value. These include the diagnosis of diseases for which vaccines are avail-

TABLE 7
VIRAL STUDIES ON PATIENTS SUSPECTED OF HAVING PERTUSSIS

Viral Agent Implicated	Age	Sex	Neut. Titer or CF Titer[1] S1	S2	Isol.	Clinical Findings	Other Lab Data
RSV	4 Y	M	<8	16	no	No immunization, paroxysmal cough, vomiting.	WBC = 15,200, P = 11, L = 76, M = 10, E = 3, N-P culture neg. for B. pertussis
RSV	11 Mo	F	<8	128	no	No immunization, paroxysmal cough, cyanosis, thick mucus, req. frequent suctioning	WBC = 11,050, P = 34, L = 62, M = 24, N-P culture neg. for B. pertussis
RSV	16 Mo	F	<8	64	no	No immunization, cough, nasal discharge, history of contact with pertussis	WBC = 12,850, P = 38, L = 61, B = 1, N-P culture neg. for B. pertussis
RSV	6 Wk	F	8	32	no	Freq. cough, history of exposure to pertussis	WBC = 8,450, P = 35, L = 61, M = 4, N-P cultures neg. for B. pertussis
RSV	16 Mo	F	<8	32	no	DPT at 4 & 6 mo., cough, whoop, cyanosis, vomiting, no history of exposure to pertussis	WBC = 21,800, P = 33, L = 63, E = 6, N-P cultures neg. for B. pertussis
Cox A9	10 Mo[2]	F	<8	32	yes	Paroxysmal cough, vomiting, no immuniz., no history of contact with pertussis	WBC = 19,600, P = 47, L = 50, M = 3, N-P cultures neg. for B. pertussis
Cox A9	10 Mo[2]	F	<8	256	yes	Paroxysmal cough, vomiting, no immuniz., no history of contact with pertussis	WBC = 17,900, P = 70, L = 28, M = 2, N-P cultures neg. for B. pertussis
E 11	12 Mo	F	8	32	yes	Paroxysmal cough, vomiting, no history of exposure to pertussis	WBC = 25,000, P = 44, L = 41, M = 3, E = 1

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[1] In absence of isolation, titer was determined by complement fixation.
[2] Twins

able, e.g., rabies, influenza, and poliomyelitis. For example, during the 1963 polio outbreak in Kent County, Michigan, a mass immunization program was instituted on the basis of virologic findings. In this instance, the State Department of Public Health Virology Laboratory isolated and identified poliovirus type 1 from early cases within three days following receipt of specimens.

Definitive laboratory diagnosis also aids the physician in the management of certain virus infections in which chemotherapy is proving effective. Although virus chemotherapy is in its infancy, its effectiveness has been demonstrated in a few instances as witnessed by the effective treatment of chronic psittacosis with broad-spectrum antibiotics and the use of pyrimidine antagonists in suppressing certain types of persistent herpetic infections.

ASIDE FROM any immediate practical value studies of the type reported here contribute toward our knowledge of virus disease in Michigan and hopefully will aid physicians in the recognition and management of similar cases in the future. The pertussis-like syndrome caused by respiratory syncytial virus (RSV) is a case in point. Characteristically, RSV infection is limited to children under two years of age. Moreover, both the blood picture, i.e., high WBC count with lymphocytosis, and the clinical symptoms mimic the bacterial disease. Four of the five patients with RSV infection who had frequent cough with cyanosis, followed by vomiting, were hospitalized because of the possibility of pertussis. RSV should therefore be considered in DPT-immunized children with symptoms resembling pertussis, especially when repeated bacteriologic cultures on these patients are negative.

Studies of the type described here also provide valuable basic epidemiologic and etiologic data required for the eventual control of virus disease through vaccination. For instance, development of the poliovirus vaccine became a possibility only after three and only three types of poliovirus had been documented. A more recent example is the adenovirus vaccine, which evolved only after extensive virologic testing implicated two or three of the 31 adenovirus types as being of major importance in respiratory outbreaks.

In general, the viruses associated with the common childhood diseases, such as mumps, measles, and rubella, produced fairly characteristic symptoms and were readily diagnosed clinically. Mumps accounts for over 40% of the meningitic and encephalitic virus disease diagnosed in Michigan, according to data collected by the Division of Epidemiology, Michigan Department of Public Health. In contrast with the present study, the statewide experience of the Virology Division indicates that in the absence of parotid swelling, mumps meningoencephalitis is diagnosed clinically only about 50% of the time.

Formerly, non-bacterial meningitis was thought to be caused chiefly by poliovirus. We now know that not only can mumps and some 50-odd non-polio enteroviruses cause CNS disease, but a few of these agents may cause paralysis as well. Thus it becomes important, especially in view of the widespread use of polio vaccine, to determine the etiology of meningitic disease. Paralytic disease was present in 12 of 14 patients included in this study from whom poliomyelitis virus was isolated. It is not likely that polio was involved in aseptic meningitis in more than two patients because the virus would have been isolated from the fecal specimens and/or serologic titers would have been demonstrated.

UNIDENTIFIED AGENTS were isolated from 21 patients. Eighteen of these patients presented with aseptic meningitis. The agents isolated were not neutralized by any of the sera produced against the commonly recognized virus types and were likewise not identifiable by workers at the National Communicable Disease Center laboratory in Atlanta, Georgia. Only two of the 18 paired sera received from these patients showed any immune response against their own isolate, suggesting that either the agents were not associated with the disease or that the patient failed to produce an immune response. The same lack of serologic response has been observed in certain cases of recurrent herpes infection.

There were 15 dual infections, proven serologically, with or without concomitant virus isolation. Mumps virus was involved in 10 and herpes simplex in five. Nine other viruses were implicated in conjunction with these agents, but mumps and/or herpes was involved in 13 dual infections. The total experience of the Health Department Virus Laboratory indicates that mumps, herpes and adenovirus are the agents most commonly encountered in multiple infections. Perhaps it could be postulated that these viruses, at least the herpes and adenovirus, may reside indefinitely within the host and initiate active infection only after the patient has been infected by another virus disease. The symptomatology produced by these dual infections is so diverse that it would appear impossible to associate symptomatology with the specific agents involved. For this reason, the clinical histories on these patients were not included in this study.

SUMMARY

Between July 1962 and July 1967, extensive virologic studies were performed on 720 patients admitted to the Communicable Disease Division of Herman Kiefer Hospital, Detroit, Michigan. Viral etiology was established in 250 or 35% of these patients. This report emphasizes the necessity for a close liaison between physician and virus laboratory because the extreme variability of clinical manifestations makes diagnosis difficult or impossible on the basis of clinical findings alone.

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special article

Medical Review And Nursing Evaluation of State Patients In Nursing Care Facilities and Homes for Aged

BY HERMANN A. ZIEL, JR., M.D.
LANSING

During this fiscal year the State of Michigan will pay over $100,000,000 in state and federal funds for the care of clients of the Department of Social Services in nursing homes, medical care facilities, and homes for the aged, under the Medical Assistance and Intermediate Care programs. Responsibility for the federally required medical review and nursing evaluation of these clients has been delegated by the Department of Social Services to the Department of Public Health, which will discharge this obligation in collaboration with local health departments.

The medical review and nursing evaluation program will be set up to cover all counties. The program will use the services of physicians and professional nurses, primarily. Social workers from county departments of social services will also be involved. The program will provide:

1. Prior authorization of skilled nursing care for individual clients. This will help assure that the client enters the facility most appropriate to his needs.

2. Evaluations every six months involving each client under Intermediate Care, and every three months for clients under Medical Assistance (Medicaid). This will include an assessment of the level or intensity of care required, and facilities' capabilities for meeting the patient's care needs, and the possibility of using alternative and perhaps less costly facilities and services.

3. Interim evaluations made at the request of the facility if changes in the client's condition are such as to justify interim evaluations.

As a basic principle, the medical and nursing care needs of the client will be the dominant consideration in determining the level — "intensity" — of care required. Also, the client's social and emotional well being, his involvement in the community, travel requirements, and the resources available will be important considerations.

Level of nursing care — "intensity" — relates to academic attainments, skills, and experience of the nurses who direct and are in charge of the nursing care necessary to carry out the physicians' orders. The three categories of patients' requirements will thus directly determine levels of nursing care. These are:

1. *Supervised residential care.* This level of care is appropriate for clients who need no nursing care. Essentially, it involves personal care, protection and assistance under lay supervision around the clock, as well as the provision of special or therapeutic diets, organized recreational and diversional activities, and attention to the

NEW STANDARDS for medical review and nursing evaluation of state patients in nursing care facilities and homes for the aged, explained in the accompanying article, were discussed by Hermann A. Ziel, Jr., M.D., left, at a recent meeting of the MSMS Committee on Rehabilitation, chaired by Lionel L. Davis, M.D., Mt. Pleasant, right.

The author is chief of the Bureau of Medical Care Administration of the Michigan Department of Public Health.

simple social needs of residents. This kind of care can be given in licensed homes for the aged.

2. *Basic nursing care.* This level of care, a benefit service under the Intermediate Care Program, is appropriate for clients who need basic or minimal nursing care and service. It involves nursing care which may properly be given in any licensed nursing home. Such care includes:

(a) Proper positioning of patients in bed, wheelchair, or other accommodation.

(b) Bed baths.

(c) Prevention and treatment of skin irritation and decubiti.

(d) Observation of vital signs and recording of findings in patient's record.

(e) Assistance and training in self-care as required for feeding, grooming, ambulation and toilet activities, and other activities of daily living.

(f) Assistance and training in patient transfer techniques.

(g) Range of motion exercises as part of routine maintenance nursing care.

(h) Administration of topical, oral and selected injectable medications. Injectable medications should be administered by licensed nursing personnel.

(i) Administration of oxygen on an emergency or short-term basis.

(j) Use of intermittent positive pressure breathing equipment and nebulizers.

(k) Simple dressings and routine care of patients with temporary casts, braces, splints, or other appliances requiring nursing care or supervision.

(l) Use of protective restraints, bed rails, binders and supports, as ordered by a physician or provided in accord with written patient care policies and procedures.

(m) Arrangements for obtaining promptly and conveniently clinical laboratory, X-ray, and other diagnostic services.

3. *Skilled nursing care.* This level of care, a benefit service under the Medical Assistance program, is appropriate for clients who need skilled nursing care on a regular or continuing basis. It involves the use of nursing techniques and services which must be provided under the direction of a registered professional nurse and in charge of licensed nurses around the clock, seven days a week. Such care includes:

(a) Administration of more potent and dangerous injectable medications and intravenous medications and solutions on a regular and continuing basis.

(b) Restorative nursing procedures such as gait training and bowel and bladder training for patients who have restorative potential and can benefit from the training.

(c) Nasopharyngeal aspiration required for the maintenance of a clear airway.

(d) Maintenance of tracheotomy, gastrostomy, and tubes indwelling in body cavities.

(The mere presence of a urethral catheter, particularly one placed for convenience or the control of incontinence, does not justify a need for skilled nursing care. On the other hand, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care. In such instances, the urethral catheter must be ordered by a physician and the need documented and justified in the patient's record.

Colostomy may require skilled nursing care during the early postoperative period. However, maintenance care of a colostomy does not justify skilled nursing care.)

(e) Administration of tube feedings.

(f) Administration of oxygen and other medicinal gases on a regular or continuing basis in the presence of an unstable medical condition.

(g) Other specified and individually justified services, including skilled nursing observation of unstable medical conditions, required on a regular and continuing basis, which can only be provided by or under the direction of trained medical and licensed professional nursing personnel. The need for these services must be documented and justified in the patient's record.

Physical therapy (and other specialized therapy services) may be required by any individual regardless of his other care needs. Thus, physical therapy may appropriately be provided to a resident in a supervised residential care facility or a patient in a basic or skilled nursing care facility. On the other hand, physical therapy services should always be ordered by a physician and directed and provided by trained personnel. In summary, the need for or provision of physical therapy is not an indication in itself of a need for skilled nursing care.

In addition to actual observation of each client, by application of criteria the medical review and nursing evaluation will consider the following:

1. The facilitiy's compliance with standards for providing a given level or intensity of care as evidenced by its current certification, operation, and condition.

2. The resident or patient record and its adequacy — personal information, diagnosis, physician's orders and progress notes, consultation reports, nurse's notes, laboratory and X-ray reports.

3. Medical — social care plans.

4. Other sources of pertinent information including the resident or patient register, incident and accident reports.

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* Doctors, tear out this list and save for reference.

Michigan Gains 2,000 Doctors in 60's; Still Far Short

Michigan increased its number of doctors of medicine from 8,818 in January of 1960 to 10,849 in December of 1969.

This record gain of 2,031 doctors of medicine in a ten-year period still left Michigan far short of physicians. Latest tabulations of the M.D. Placement Service of the Michigan Health Council show a need for at least 600 more family physicians. Some of the 142 communities need only one more family doctor while some larger communities need 25 or more family doctors. There now are 75 Michigan communities in need of medical specialists with internal medicine, pediatrics, Ob-Gyn, public health, neurology and neuro-surgery, general surgery and orthopedic surgery ranking high in the list.

RURAL AREAS of Michigan continue to be the principal problem areas. In recent surveys made by the Council in southwestern Michigan, the doctors of medicine and hospital administrators estimated a need for 25% more physicians with openings for 99 more family doctors and 189 more specialists. The Upper Peninsula doctors and administrators estimated a need for nearly a 50% increase of doctors in the Upper Peninsula. The shortage of medical doctors is not confined to these two areas of Michigan. Requests for assistance in finding new physicians are coming from all areas including the Metropolitan Detroit and southeastern Michigan counties.

During the past decade nearly every county in Michigan has obtained several doctors of medicine through the M.D. Placement Service of the Michigan Health Council. The Placement Service is guided by the Michigan State Medical Society and assisted financially by The Upjohn Company of Kalamazoo. During this period nearly 1,000 medical doctors have been assisted in finding a location. Among the Michigan communities helped recently were Ann Arbor, Battle Creek, East Lansing, Galesburg, Grayling, Sault Ste. Marie, South Haven, Traverse City, Jackson, West Branch, and Ypsilanti.

The Michigan Health Council has recommended that our medical schools be given necessary funds so that at least 500 to 600 students can be admitted annually during the 1970's rather than the 250 to 300 that have been admitted annually during the 1960's.

THE COUNCIL also has recommended that the Basic Science requirements be eliminated or amended so that graduates of American medical schools can enter Michigan with a minimum of red tape and delay. Far too many graduates of American medical schools were reluctant to take the time and trouble to make extra trips to Michigan to take the Basic Science examination when they could go to nearly any other place in the United States. In the surveys made by the Council, over 80% of the doctors in southwestern Michigan and in the Upper Peninsula recommended that the Basic Science examination be eliminated.

TWELVE MSMS MEMBERS APPOINTED TO 12 AMA COMMITTEES

An important share of the members of AMA committees for 1970 are Michigan physicians — a total of 12 MSMS members have been appointed or reappointed to 12 different committees and councils. Two Michigan physicians hold more than one appointment. The list includes:

Donald J. Birmingham, M.D., Detroit, reappointed to the Committee on Rating of Mental and Physical Impairment

Bertram D. Dinman, M.D., Ann Arbor, reappointed to the Committee on Occupational Health

Otto K. Engelke, M.D., Ann Arbor, reappointed to the Council on Environmental and Public Health; and appointed to the Joint Committee on Environmental Health

Harold F. Falls, M.D., Ann Arbor, appointed principal to the Interspecialty Committee on Ophthalmology of the American Academy of Ophthalmology and Otolaryngology; and reappointed to the Council on Health Manpower

Alexander H. Hirschfeld, M.D., Detroit, reappointed chairman of the Joint Committee on Mental Health in Industry

William W. Jack, M.D., Grand Rapids, reappointed to the Committee on Maternal and Child Care

Clarence Livingood, M.D., Detroit, reappointed alternate to the Interspecialty Committee with the American Academy of Dermatology

Herbert A. Raskin, M.D., Detroit, reappointed to the Committee on Alcoholism and Drug Dependence

Richard C. Schneider, M.D., Ann Arbor, reappointed to the Committee on the Medical Aspects of Sports

Maurice H. Seevers, M.D., Ann Arbor, reappointed to the Committee on Alcoholism and Drug Dependence

Starling D. Steiner, M.D., Detroit, reappointed to the Committee on Occupational Health

Donald N. Sweeny, Jr., M.D., Detroit, reappointed to the AMA Disability Insurance Claims Review Committee

about doctors

LT. GENERAL HAL BRUCE JENNINGS, JR., MC, a University of Michigan School of Medicine graduate, has been appointed Surgeon General of the U. S. Army. Lt. Gen. Jennings has served as deputy surgeon general since July 1, 1969, and from May, 1968 until that time served as Command Surgeon, U. S. Military Assistance Command, Vietnam.

DONALD C. SMITH, M.D., ANN ARBOR, professor of maternal and child health and chairman of the Department of Human Development at the University of Michigan School of Public Health, has been appointed Chairman of the Medical Assistance Advisory Council to advise HEW Secretary Robert H. Finch on administrative policy for the Medicaid program.

AFTER 34 YEARS as a general practitioner in Battle Creek, Clark W. Royer, M.D., plans to retire, head west and relax. He and Mrs. Royer will return each year to spend some time at their cabin at Trout Lake in the Upper Peninsula, however, and Doctor Royer plans to assist at surgery with the Southwestern Regional Rehabilitation Center. Doctor Royer, former president of the Calhoun County Medical Society and the Michigan Chapter of the American Academy of General Practice, and Mrs. Royer have a new home in Sun City, Ariz.

NORMAN C. WESTLUND, M.D., SAGINAW, has been named a life member of the American Academy of Child Psychiatry. Doctor Westlund was one of the charter members of the association.

BERTRAM D. DINMAN, M.D., ANN ARBOR, has been named director of the University of Michigan's Institute of Environmental and Industrial Health. Former acting director of the U-M Institute of Industrial Health, which was redesignated the Institute of Environmental and Industrial Health, Doctor Dinman will become associate chairman of the U-M Department of Environmental and Industrial Health.

W. A. GILPIN, M.D., BLOOMFIELD HILLS, was a member of a panel discussing "Man As An Endangered Species" at the 66th annual meeting of the Michigan Audubon Society.

Established 1924

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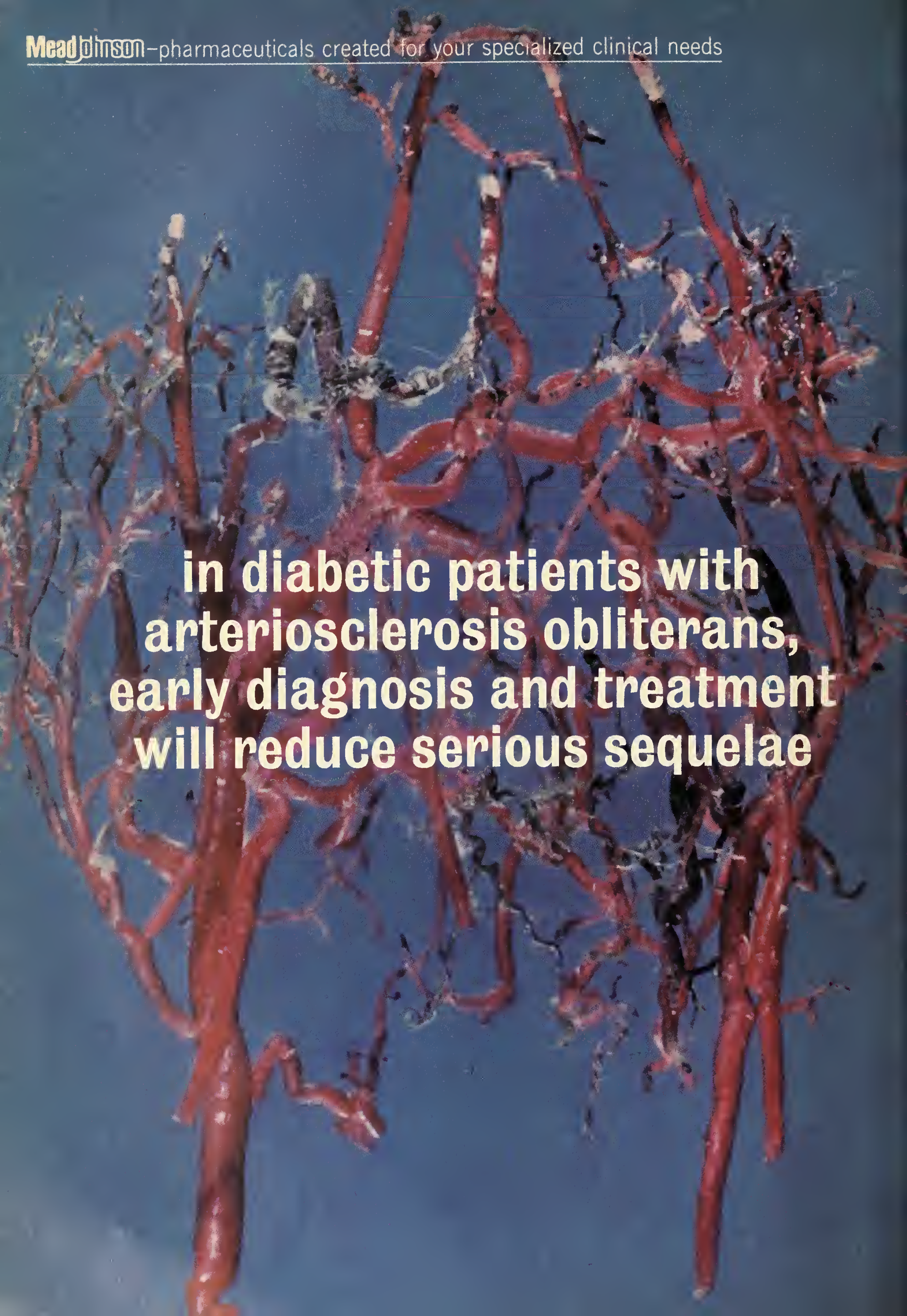

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Although not all clinicians agree on the value of peripheral vasodilators,[6-8] several investigators[4,5] have reported favorably on the effects of isoxsuprine on peripheral blood flow in skeletal muscle vessels. Effects have been demonstrated both by objective measurement[1,5,9] and observation of clinical improvement.[4,10-12]

Indications: Arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODĪLAN tablets, isoxsuprine hydrochloride 10 mg. **Dosage:** Oral—10 to 20 mg. (1 or 2 tablets) t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories.

References: (1) Stein, I.D.: Angiology *15*:1 (April) 1964. (2) New Drugs–Evaluated by the A.M.A. Council on Drugs, Chicago, American Medical Association, 1967, pp. 295-297. (3) Samuels, S. S., and Shaftel, H. E.: J. Indiana M. A. *54*:1021-1023 (July) 1961. (4) Kaindl, F.; Pärtan, J., and Polsterer, P.: Wien.klin.Wchnschr. *68*:186-191 (March 16) 1956. (5) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: Angiology *10*:185-192 (Aug.) 1959. (6) Myers, K. A.: Modern Treatment *4*:370-383 (March) 1967. (7) Gillespie, J. A.: Angiology *17*:280-288 (May) 1966. (8) Smit, Arne, F., *et al.*: Nordisk Medicin *20*:1260, 1959. (9) Samuels, S. S., and Shaftel, H. E.: JAMA *171*:142-145 (Sept. 12) 1959. (10) Frieh, C., and Olivier, L.: Lyon Med. *91*:891-896 (May 24) 1959. (11) Weghaupt, Von K.: Wien.klin.Wchnschr. *69*:31-32 (Jan. 11) 1957. (12) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960.

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Microphoto of occluded vessels in gangrenous area of a first toe amputated because of severe arteriosclerosis obliterans. Cast was made by injecting acrylic plastic into the vessels. *Used with permission. Courtesy of Margaret C. Conrad, Ph.D., Department of Physiology, Bowman-Gray School of Medicine, Wake Forest College, Winston-Salem, N. C.*

68069

editorial viewpoints

Doctor Jack Praises Maternal Health Committee In Just-Released History

BY BROOKER L. MASTERS, M.D.,
CHAIRMAN
MSMS PUBLICATION COMMITTEE

Because of the work of many physicians on the MSMS Committee on Maternal Health since its beginning in 1932, "uncounted thousands of women and children are healthier and happier today."

That tribute is paid by W. W. Jack, M.D., Grand Rapids, former committee chairman, 1961-67, in a history of the MSMS Committee on Maternal Health that he recently completed.

And members of The MSMS Council, officials of the State Health Department, and many others would agree that the committee has contributed much.

In the historical piece, Doctor Jack recalls that "The Committee on Maternal Health had its origin as a Committee on Birth Control appointed by the Speaker of the House of Delegates in 1932." The name was changed to the present name in 1933.

The Committee has accomplished much. In 1942, the Committee began its efforts to transfer the licensing of maternity hospitals from the State Department of Social Welfare to the Department of Health and that effort "was finally successful."

The review of the Committee minutes reported many times the work of the Michigan Maternal Mortality Study, launched in 1950 after much previous discussion.

Doctor Jack recalls the pages of "Obstetrical Brevits" which appeared in the MSMS journals for several years beginning in 1957. Later, the Desk Reference Cards were developed.

The committee history describes the continuing education efforts of the two-day committee workshops that have been held each year since 1962; and the larger conferences on Maternal and Perinatal Welfare now held in Flint each spring.

The Committee efforts to urge the adoption by the State Legislature of a Family Life Education Bill in 1968 were recalled.

These few excerpts from the committee history are very brief, but they quickly prove the importance of the work of this excellent MSMS Committee and its knowledgeable and loyal members.

The author closes his committee history by dedicating it to Alexander M. Campbell, M.D., and Norman F. Miller, M.D., for their contributions over the years. The entire history is filed in the library at MSMS headquarters.

One can only conclude that if all MSMS Committees were as vigorous as this one, the image of organized medicine in Michigan would be a much brighter one.

Medical Families Can Aid Political Process At Grassroots Level

BY MRS. EDWARD R. WEDDON
MDPAC BOARD OF DIRECTORS

There's no question about it. Doctors and their wives are busy people.

In addition to family, church and work, they are generally involved in organizational projects and committee work as leaders in their communities.

But the time has come to analyze whether or not these activities are doing the job that needs to be done.

The tentacles of governmental bureaucracy, via Medicare and Medicaid forms, are reaching deeper into every medical practice.

Proposals for national health programs, with further inroads and almost total control, are springing up like mushrooms in the halls of congress.

Surely it should not take a bolt from the blue to illuminate the fact that such proposals result in laws, passed and enforced, by elected government office holders.

NO "MEDICAL" FAMILY can afford to remain aloof from the political arena where these government officials are selected, promoted and elected.

This, then, is the job that needs doing.

How?

For starters, both doctors and their wives can become members of the Michigan Doctors Political Action Committee, (MDPAC).

Organized approximately five years ago, MD-

(Continued on Page 239)

Painful night leg cramps...

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One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

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emerging as a major therapeutic problem—

recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]

recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

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References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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PAC is the political arm of the Michigan State Medical Society.

Memberships are $25 for Doctors, $10 for Auxiliary members, $5 for students, interns or residents. (These can be mailed to MDPAC, Box 169, East Lansing.)

Funds are used to support qualified candidates for political office, as well as to give backing to citizens who might not otherwise feel they can afford to enter a campaign.

MDPAC funds are also used to conduct political workshops with a special welcome to wives of doctors.

THE IMPORTANCE of women's work is twofold. Doctor-husbands do not always have the time to devote to "politicking," so she can be of great assistance in this field. Not only can she volunteer time but she can see that his views are represented.

Each county auxiliary should have at least one person working actively with MDPAC. If there is no constitutional provision for a MDPAC chairman, an assistant to the legislative chairman can be representative. Volunteer your name now.

With the ability and enthusiasm of doctors' wives, there is no question but what the political structure in this state could be influenced drastically.

Here's what you can do. Now.

Go to your County Clerk's office and get a nominating petition to become a delegate to the County Convention. Have 18 registered voters in your precinct sign the petition and turn it back in by 4 p.m., E.S.T., May 26, 1970. Your name will appear on the ballot.

Delegates from each precinct will be elected in the Aug. 4, primary.

This procedure is established by law and is the essence of the "grass roots" level which is so vital.

Elected delegates are notified when and where the county convention is to be held. At this meeting they will vote for delegates to the state convention. Put your bid in for this too.

At the state convention delegates will nominate the party's candidate for secretary of state, attorney general, other state posts in the field of education and the judiciary.

Because delegates are elected for two year terms, those elected in the Aug. 4 primary will be the ones who will also select delegates to the national convention at the 1971 state meet.

AS A DELEGATE from your precinct you will learn that local, county, state and national candidates all need your help. They will rely on you for mailing lists, telephoning, putting up posters, recruiting help for and manning local campaign headquarters. You can introduce them to people in your area, arrange meetings, coffees or teas for them in the area where they can meet a large number of people in a short time.

As much effort and time as you can provide are deeply appreciated by candidates and they in turn are pleased when there is some way they can help you later on.

By organizing support committees in your community, you can also be effective. MDPAC has a doctor in each congressional district who can advise you on candidates the board is supporting and will welcome your recommendations. Many times candidates desperately need someone to see that their literature is distributed or telephone calls are made. One good worker in each precinct can make the difference in whether or not a qualified candidate is elected to office. And his one vote can be critical to good legislation.

Unless each citizen is willing to do his share in keeping the democratic processes functioning, he should not complain about candidates he does not like, the election of unqualified officials or the passage of legislation not to his liking.

So remember, it all begins with you . . . right in your precinct.

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- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

msms news

Michigan Mediscene

Mar. 11 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Mar. 16 — American College of Emergency Physicians, Board Meeting, MSMS Headquarters, East Lansing, 5 p.m.

Mar. 18-19 — MSMS WOMAN'S AUXILIARY SPRING CONFERENCE, Midland

Mar. 25-26 — 9th ANNUAL MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL HEALTH, Pick-Durant Hotel, Flint.

Apr. 13 — American College of Emergency Physicians, Board Meeting, MSMS Headquarters, East Lansing, 5 p.m.

Apr. 22 — MSMS COUNCIL, Towsley Center, Ann Arbor, 9:30 a.m.

Apr. 23-26 — MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY ANNUAL MEETING, Pontchartrain Hotel, Detroit

Apr. 30 — 1970 MSMS CONFERENCE ON MEDICAL ASPECTS OF HIGH SCHOOL SPORTS, Towsley Center, U-M, Ann Arbor

May 6 — MICHIGAN CANCER COORDINATING COMMITTEE, MSMS Headquarters, East Lansing, noon

May 6-8 — Michigan Public Health Association Annual Meeting, Statler-Hilton Hotel, Detroit

May 12-24 — 1970 Medical Staff-Trustee-Administrator Forum sponsored by the Michigan Hospital Association at Boyne Mountain Lodge

May 15-16 — Michigan State Association of Industrial Nurses annual Spring Conference, Holiday Inn, Midland

May 21-22 — MSMS ANNUAL MATERNAL HEALTH CONFERENCE, Kellogg Biological Station, Gull Lake

May 27 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

June 17 — MSMS COUNCIL, MSMS Headquarters, East Lansing, noon

June 21-25 — American Medical Association Annual Convention, Chicago

July 23-25 — MSMS MID-SUMMER SESSION OF THE COUNCIL, Grand Hotel, Mackinac Island

Sept. 20 — MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit, 9:30 a.m.

Sept. 20-24 — MSMS ANNUAL SESSION, Sheraton-Cadillac Hotel, Detroit

Sept. 23 — MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit, 8 a.m.

Sept. 25-Oct. 2 — American Academy of General Practice Scientific Assembly, San Francisco

Nov. 4 — MSMS COUNCIL, MSMS Headquarters, East Lansing, noon

Nov. 11 — MICHIGAN CANCER COORDINATING COMMITTEE, MSMS Headquarters, East Lansing, noon

Nov. 29-Dec. 2 — American Medical Association Clinical Convention, Boston

Dec. 9 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

RE-ELECTED OFFICERS of the MSMS Judicial Commission are Harold A. Furlong, M.D., Pontiac, left, vice chairman, and Donald N. Sweeny, Jr., M.D., Detroit, chairman, who were designated at the January meeting to continue as leaders of the commission during 1970.

NEW MEMBERS of the MSMS Judicial Commission, elected in December, were welcomed to their first commission meeting in January by Donald N. Sweeny, Jr., M.D., Detroit, right, chairman. From left are H. Maxwell Golden, M.D., Flint, elected from the Fourth District, and C. Allen Payne, M.D., Grand Rapids, of District 6. Another new member, Clarence S. Livingood, M.D., Detroit, of the First District, was not present.

SEVERAL MSMS COMMITTEES HAVE NEW CHAIRMEN

Several MSMS committees have new chairmen, appointed in recent months to lead them through 1970's activities. There are 10 new chairmen who face organizational jobs to move their committee study and projects ahead. They are:

Cardiac Disease Control — Michael C. Kozonis, M.D., Pontiac
Michigan Medical History — Irving F. Burton, M.D., Detroit
Occupational Health — Duane L. Block, M.D., Dearborn
Education Liaison — John R. Pedden, M.D., Grand Rapids
Awards — James J. Lightbody, M.D., Detroit
Courses on Medical Economics and Ethics — C. Howard Ross, M.D., Ann Arbor
Liaison with Michigan Chapter of the Health Insurance Council — Brock E. Brush, M.D., Detroit
Liaison with Michigan State Pharmaceutical Association — Robert E. Rowe, M.D., Port Huron
Planning and Priorities — Brooker L. Masters, M.D., Fremont

JIM
DUSTY
HAROLD
BOB
RUSS
KEN
PAUL
JACK
ROGER
ROSS
JOHN
FRANK
FRED
LOU

A WARM, INFORMAL atmosphere was set for the January meeting of the MSMS Legal Affairs Committee from the time they entered the door. They found the traditional name tags boldly lettered with their nicknames — "Bob, Lou, Russ, Charlie, Jack, Otto." There was no doubt who was who from across the table and Francis P. "Dusty" Rhoades, M.D., Detroit, left, and James A. "Jim" Read, M.D., Birmingham, had no difficulty selecting their tags from the board at the door.

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OPHTHALMOLOGISTS', OPTOMETRISTS' ROLES CLARIFIED

To clarify the roles of ophthalmologist and optometrist for society members, the MSMS Committee on Eye Care offers the following information:

The role of the ophthalmologist and optometrist in reading disability must be prefaced by a definition of each. The following is taken from the United States Department of Health, Education and Welfare, Health information Series, No. 64.

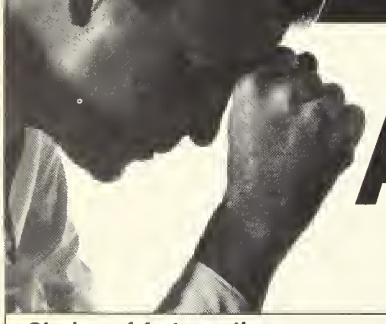
1. An ophthalmologist or oculist is a physician, a doctor of medicine, who specializes in diagnosis and treatment of defects and diseases of the eye, performing surgery when necessary or prescribing other types of treatment including glasses.
2. An optometrist is a licensed, nonmedical practitioner who measures refractive errors — that is, irregularities in the size or shape of the eyeball or surface of the cornea — and eye muscle disturbances. In his treatment the optometrist uses glasses, prisms, and exercises only.

Both the ophthalmologist and the optometrist have a definite responsibility in the area of dyslexia. Each child with a reading or learning disability must have a complete ocular examination, and borderline errors should be corrected to give the child the benefit of the doubt. However, since it is a well-confirmed fact that ocular defects play only a small part in this area, all children with reading or learning difficulty should have the benefit of a complete physical, psychiatric, and psychological evaluation. Each portion of the total examination should be carried out by a person especially trained in that particular field. This should be supervised by the child's pediatrician or family physician, and he should be the one to decide on the proper program of rehabilitation and re-education to be followed.

It is, therefore, a serious mistake for either the ophthalmologist or optometrist to work alone in diagnosing or treating learning defects, whether these defects be referred to as dyslexia, perceptual mal-development, usual perception problems, or by any other name.

The child's personal physician is responsible for the total management of the teaching problem including proper referral for all necessary diagnostic studies. He is also responsible for the supervision of care after a diagnosis has been established.

The Committee on Child Welfare wishes to express concern that neither the child be exposed to unnecessary procedures nor the family to unusual expense.



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impotence
in the American male is complex.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

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T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society

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Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Ketosteroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

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Methyl Testosterone . . 2.5 mg.
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Glutamic Acid . . . . 50 mg.
Thiamine HCL . . . . 10 mg.
Dose: 1 tablet 3 times daily
Available:
Bottles of 100, 500, 1000.

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EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . . 64 mg.
Glutamic Acid . . . . 50 mg.
Thiamine HCL . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
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Thyroid Ext. (¼ gr.) . . . 15 mg.
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Thiamine HCL . . . . 25 mg
Glutamic Acid . . . . . . 100 mg.
Pyridoxine HCL . . . . 5 mg.
Niacinamide . . . . 75 mg.
Calcium Pantothenate . 10 mg
Vitamin B-12 . . . . 2.5 mcg
Riboflavin . . . . 5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications – Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. **Montesano, P., and Evangelista**, I. Methyltestosterone-thyroid treatment of sexual impotence Clin Med 12-69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound West Med 5 67, 1964 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25-6, 1962 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19 936, 1959 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79-863, 1958 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p 1432 7. **Wershub, L. P.** Sexual Impotence in the Male Thomas, Springfield, Ill., 1959, pp 79-99

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THANK YOU FOR PUBLICATION OF AMA DELEGATES' REPORT

To the Editor:

As chairman of the American Medical Association Delegates for the Michigan State Medical Society, I wish to thank you for publishing the resume of the Report of the Committee on Development and Planning of the AMA in *Michigan Medicine*. This will allow our membership at large to have knowledge of the problems as we see them in the national arena.

Sincerely yours,
Donald N. Sweeny, Jr., M.D.

(*The report of the MSMS delegates to the AMA was published in the Breaking News pages of the January issue of Michigan Medicine.*)

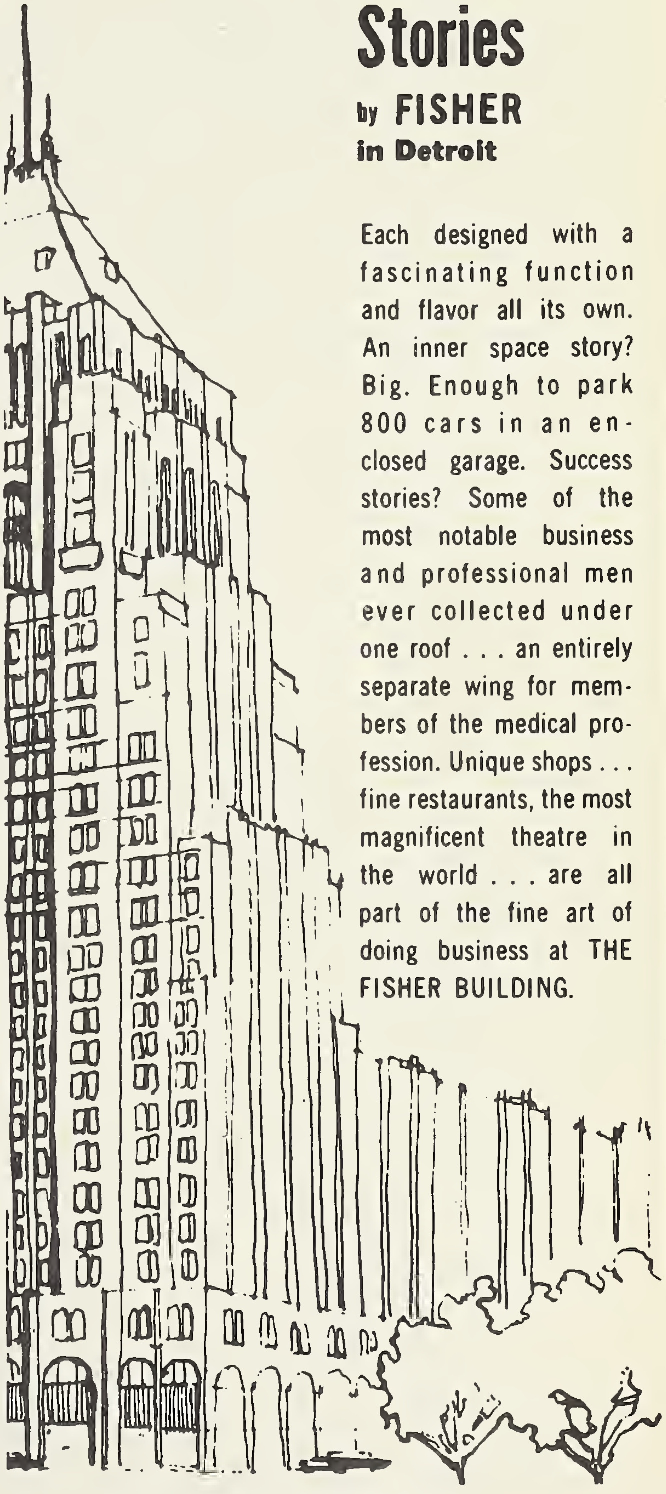
DOCTOR MASON HEARS FROM MISSOURI OSTEOPATH

(*Editorial Note: The following is a letter from a Missouri osteopath, who, on his own initiative, attended the AMA House of Delegates meeting in Denver, and expressed his own warm feeling toward cooperation with the AMA and medicine in general. He made himself available for discussion about his ideas of young D.O.'s viewpoints and conferred with various members of the MSMS and other state delegations.*)

Doctor Mason,

I appreciate so much meeting you and the opportunity of expressing the viewpoints which I am more than sure represent the thinking of the young osteopath. I probably will be in Michigan sometime in January and perhaps February of 1970. I hope I can again chat with you. I'll let you know ahead of time and hopefully the time will be favorable for a meeting with you.

Again, thanks so much for your friendliness, interest, and consideration.



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"A WEEK with the Legislature," a guide to lobbying successfully for MSMS in the Michigan legislature, is eagerly studied by Louis R. Zako, M.D., Detroit, left, and Robert J. Huebner, M.D., Hastings, right. Under the direction of M. A. Riley, center, MSMS legislative counsel, Doctor Huebner and Doctor Zako were the first physicians to spend a week in Lansing as Volunteer Physician Representatives for MSMS. An account of Doctor Huebner's experiences, and further details of the new program, are included in the accompanying article.

Doctor Huebner's Week with Legislature "Enjoyable, Enlightening"—Successful

BY JUDITH MARR
MANAGING EDITOR

"This is the best thing the medical society has ever done!"

The exclamation from a Michigan lawmaker greeted R. J. Huebner, M.D., Hastings, on one of many visits to legislators' offices during the week of Jan. 19-23.

Doctor Huebner was the first of about 20 MSMS members scheduled to spend a full week in Lansing as Volunteer Physician Representatives for MSMS to the Michigan legislature. The other MSMS members will succeed him for one-week stays until the 1970 legislative session ends.

Their mission is to be an individual M.D. at the service of lawmakers who wish to discuss issues, to visit and call on those legislators and to be available as a source of information. In doing so, they will set forth the goals and viewpoints of organized medicine in Michigan.

THE PROJECT was well received in its first week, Doctor Huebner reports.

And if his experience is repeated, the program, originated within the MSMS Legal Affairs Committee and approved by the MSMS House of Delegates in its 1969 annual meeting, will be a great success.

"It was a tremendously enlightening week," emphasizes Doctor Huebner. "I was shocked sometimes at what the lawmakers thought of us. But it was a challenge to help them change from name-calling to first-name calling. The legislators are finding out not all physicians wear horns."

Doctor Huebner had "a great time."

"It was tremendously enjoyable," he continues. "Every single legislator or aide I met wanted to commend MSMS for initiating the project. They are looking forward to meeting the other doctors scheduled to visit the legislature."

The legislators were pleased that MSMS was taking the positive approach to presenting its members and viewpoints, he adds. The lawmakers freely discussed the problems they feel organized medicine has and were anxious to provide insight into how the legislator thinks and why he votes as he does, said Doctor Huebner.

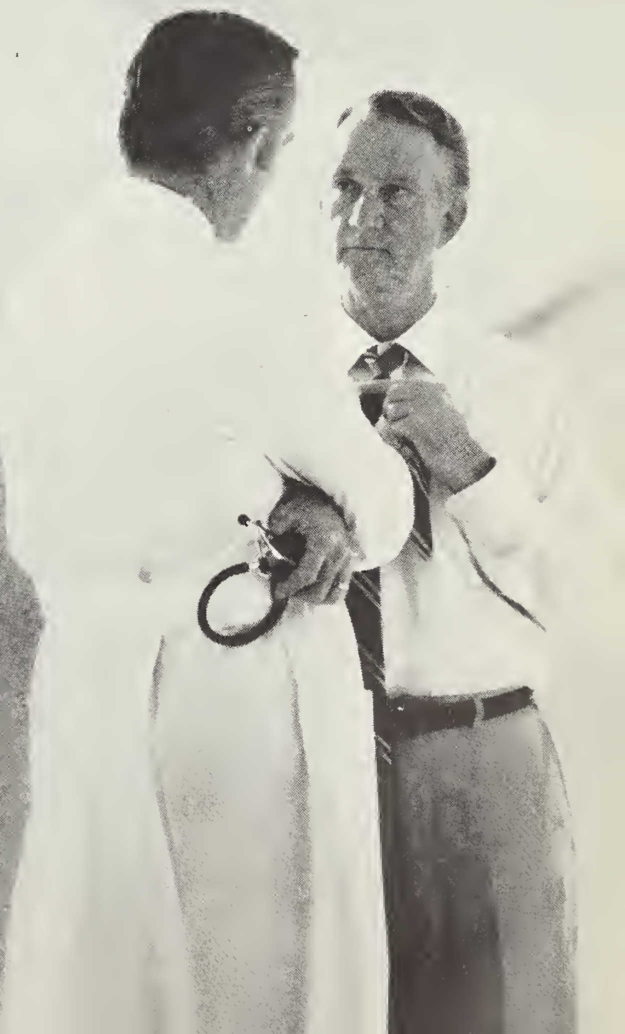
"You learn that the basic work of the legislator is not always done in the hallways of the House and Senate, nor even on the floor," he says. "Much work is done in the hotel lobby, lounge or breakfast room, and some of it is done in the legislator's office.

"These men are basically very busy," the doctor continues. "Some are so busy they can allot you just five minutes of talk — if you're lucky you can stretch it to 20 minutes."

HE URGES that the next volunteer representatives become acquainted with legislators' staffs as well as the lawmakers themselves, and that they be forthright, friendly and positive.

More hints to a successful week with the legislature are presented to the visiting physician in notebook form by the MSMS staff. The notebook, entitled "A Week with the Legislature," contains counsel on such topics as "You and the MSMS Staff as a Team, The Machinery of Government, the Lawmaker's Job, Lobbying Techniques" and "Pitfalls." Also included are important telephone numbers, personages and short statements of MSMS positions on medical issues.

In addition to this help, the MSMS staff briefs and debriefs the physician as his week goes along, keeps in close contact with him each day and arranges some meetings with legislators.



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Departing New York — May 29 at 5 p.m.
Returning New York — June 11 at 8 p.m.

All MSMS members are invited to enjoy this 13-day travel experience on board the luxury liner S.S. Santa Paula of the Grace Line. The Michigan Association of the Professions 1970 Congress will be conducted on board ship during the cruise.

Among the stops along the ship's route are some of the Caribbean's most colorful ports —

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CURACAO, DUTCH WEST INDIES
ARUBA
HAITI
CARACAS, VENEZUELA
JAMAICA

Cabin rates start at $506.85 per person, including all meals, ship transportation, entertainment and shipboard activities and services.

Reservations are being accepted now, and may be made with the Michigan Association of the Professions, Box 1212, Lansing, Mich. Requests are on a first-come, first-served basis. A deposit of $200 per person is required once staterooms are assigned, with final payment due April 15.

A color brochure and full plans will be mailed to all MSMS members.

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Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Actions—Ovulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen depresses the output of both the follicle-stimulating hormone (FSH) and the lutenizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates in the United States found relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives. This has not been confirmed in the United States.

Ovulen-21 Com
Directions

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for 2 months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: Increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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1. Royal College of General Practitioners: Oral Contraception and Thromboembolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967.
2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968.
3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969.
4. American Journal of Epidemiology (to be published).

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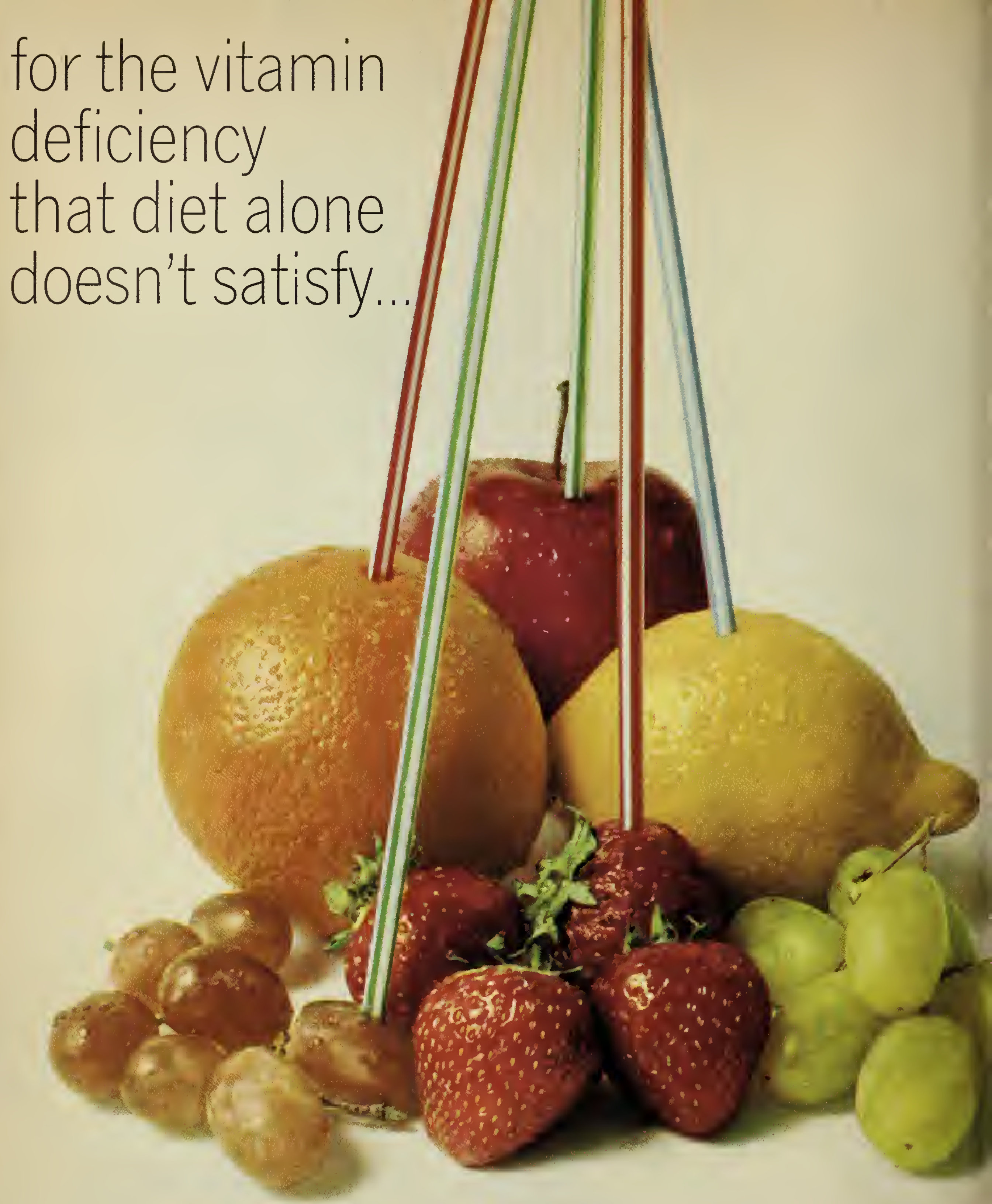
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socio-economics

The Doctor's Income Tax Calendar

March 16 — If your contributions to your employes' Social Security plus the Social Security and income taxes withheld from their salaries exceed $100 in February, complete Form 501 and pay the taxes.

April 15 — If you have not done so already, file your Federal income tax return, Form 1040, and pay any balance still owed on your income tax for 1969. Also complete Schedule C-3 and pay any remaining balance of your 1969 Social Security tax of $538.20. If you practiced in a partnership or a corporation in 1969, report your share of the earnings on your Form 1040 and make sure that the partnership or corporation files its return. This is also the final date to file an estimate of your 1970 income on Form 1040-ES and pay one-fourth. If your contributions to your employes Social Security plus the Social Security and income taxes withheld from their salaries exceeded $100 in March, complete Form 501 and pay the taxes.

April 30 — Pay the balance of your first-quarter contributions to your employes Social Security, plus the 1970 Social Security and income taxes withheld from their salaries through March 31; file Form 941. If the taxes exceeded $2,500 in any month of the preceding quarter, you must now remit semimonthly.

May 15 — If your contributions to your employes' Social Security plus the Social Security and income taxes withheld from their salaries exceeded $100 in April, complete Form 501 and pay the taxes.

June 15 — Pay the second installment of your 1970 Federal Tax (one-fourth of your estimated income tax and one-fourth of your 1970 Social Security tax of $538.20). If your taxable income so far this year has varied by 10 per cent or more from your original estimate, it's advisable to file an amended Form 1040-ES. (Use the quarterly payment form you received for this purpose.) If your contributions to your employes' Social Security plus the Social Security and income taxes withheld from their salaries exceeded $100 in May, complete Form 501 and pay the taxes.

State Governments Contribute To Funds Of Medical Schools

State governments contributed $142 million to the support of U.S. medical schools for the year 1966-67, according to figures released recently by the Association of American Medical Colleges.

A total of 46 public schools received $129 million in state appropriations and eight private medical schools received $12 million.

MORE PEOPLE IN U.S. OWN PRIVATE HEALTH INSURANCE

A record 176 million persons in the U.S. owned some form of private health insurance as the new year began. The total — an increase of more than six million over the previous year's high — represents a 4% increase over the number of persons insured at the beginning of 1969. These figures are provided by the Health Insurance Institute as part of its year-end estimates of health insurance coverage in the U.S.

The latest figures bring the total number of people with private health insurance to about seven out of eight in the U.S. Previously it was six out of seven.

The institute estimates that 1969 saw increases in the number of persons protected by all major forms of private health insurance.

Americans received $13.5 billion from private health insurance during 1969 to help pay their health care bills. The total represents an annual gain of more than $1 billion in benefits — the greatest one-year increase in private health insurance history.

ENVIRONMENTAL CENTER FORMED AT MSU

A new Center for Environmental Quality has been formed at Michigan State University, to unite the university's major resources against environmental threats to humanity.

The College of Human Medicine and the Institute of Biology and Medicine will contribute brain power to the new center, along with the colleges of arts and humanities, agriculture, economics, education, engineering, natural science, urban affairs, veterinary medicine.

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to help your
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liquefies thick, viscid mucus in chronic bronchitis and emphysema

Mucomyst, as 20% acetylcysteine, has been used with safety and effectiveness in hospitals for over five years.

Now a new 10% solution, Mucomyst-10, offers you the choice of prescribing a lesser concentration whenever you feel this is desirable. It provides added convenience and simplicity, particularly for your patients using nebulizing units at home.

By including Mucomyst-10 in the home management regimen, you can provide full mucolytic benefits for many of your patients with chronic bronchitis and emphysema complicated by tenacious secretions.

Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings: After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched carefully. If bronchospasm progresses, this medication should be immediately discontinued. Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied: Mucomyst-10 (acetylcysteine)**, a sterile 10% solution, in vials of 10 ml. and 30 ml.; **Mucomyst (acetylcysteine)**, a sterile 20% solution, in vials of 10 ml. and 30 ml.

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MIDLAND, SAGINAW PROGRAMS APPROVED FOR FAMILY RESIDENCY

Two Michigan programs designed to train residents in the new specialty of family medicine are the first in the state to win approval by the American Board of Family Practice.

The Midland Hospital Family Practice Residency Program, the first in the state to be approved, received notice of its acceptance in December from the Residency Review Committee for Family Practice of the American Board of Family Practice.

The Saginaw Affiliated Hospitals, a total community effort aimed at providing the new Family Physician training program, received its approval Jan. 12. It brought the total of approved programs in the United States to 31.

The Midland Hospital, in affiliation with the University of Michigan Medical Center, has been providing a two-and-one-half year family practice program since 1966. With the establishment of the American Board of Family Practice, the program was modified and extended to meet the new standards established by the ABFP. A new model office for family practice for use in the Midland program was expected to be completed and opened to patients in February.

Departments of Family Medicine have been established in three Saginaw hospitals under the Affiliated Hospitals organization. Completion of residency programs within either the Midland Hospital Family Practice or Saginaw Affiliated Hospitals programs qualifies the physician to apply to the American Board of Family Practice to take the examination for certification.

ACP SCHEDULES ANN ARBOR MEETING ON RHEUMATIC DISEASES

The American College of Physicians will present a five day meeting on Rheumatic Diseases: Their Pathogenesis, Diagnosis and Treatment, March 30-April 3 at Towsley Center, the University of Michigan Medical Center, Ann Arbor.

William D. Robinson, M.D., F.A.C.P., Ann Arbor, is director of the course, designed to provide a comprehensive but integrated review of rheumatic diseases.

Want to Know More About MDPAC? Contact Board Members

"MSMS members who would like to know more about MDPAC and its work are urged to contact the members of the MDPAC Board of Directors, listed below," invites Donato F. Sarapo, M.D., Adrian, chairman of the board.

The MDPAC board members are urging more MSMS members to join AMPAC and MDPAC. Information about the dues, billing procedure, and activities may be obtained by writing to MDPAC, Box 169, East Lansing.

The MDPAC board is comprised of a physician from each MSMS councilor district. Each will help form candidate support committees to help candidates on the basis of political principles, need for help, and other factors. Both MDPAC and AMPAC support candidates on a bi-partisan basis.

Doctor Sarapo reports that each of the 50 states now has an active PAC unit, and that "their force is growing."

Following is a list of MDPAC board members from the MSMS councilor districts:

Wayne: Louis R. Zako, M.D., Allen Park
Wayne: William O. Mays, M.D., Detroit
Wayne: Alexander Blain, III, M.D., Detroit
Wayne: Arthur Goldberg, M.D., Detroit
Wayne: Frank B. Walker, II, M.D., Grosse Pte. Park
Wayne: Frederick W. Engstrom, M.D., Dearborn
2. Donato F. Sarapo, M.D., Adrian
3. Thomas R. Berglund, M.D., Portage
4. Robert E. Reagan, M.D., Benton Harbor
5. William G. Zimmerman, M.D., Grand Rapids
6. Edward R. Weddon, M.D., Stockbridge
7. Glenn E. Moore, M.D., Flint
8. Robert Jardinico, M.D., Saginaw
9. F. James Stubbart, M.D., Muskegon Heights
10. Jack M. Stack, M.D., Alma
11. James Greenwood, M.D., Alpena
12. Thomas J. Setter, M.D., Mt. Clemens
18. Paul T. Lahti, M.D., Royal Oak
19. F. Gaensbauer, M.D., Pontiac

At Large:
Robert J. Fisher, M.D., Ypsilanti
V. A. Marks, M.D., Midland
G. M. Wilson, Jr., M.D., Marquette
Leonard Howard, M.D., Battle Creek
Robert Perry, M.D., Lansing

Auxiliary Mrs. Edward Weddon, Stockbridge

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PRECAUTIONS: *Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with* BENYLIN EXPECTORANT *should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing* BENYLIN EXPECTORANT.
ADVERSE REACTIONS: *Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.*
PACKAGING: *Bottles of 4 oz., 16 oz., and 1 gal.*
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xiety is expected in the cardiovascular patient.
little may even be desirable.

t when anxiety is exaggerated . . . when it
erferes with sleep . . . when it aggravates
rdiovascular symptoms, your help may
needed.

turally, you'll want to reassure the patient.

d perhaps prescribe Equanil (meprobamate)
adjunctive therapy. It helps relieve anxiety
d tension specifically, yet gently.

most 15 years' use has shown that Equanil
usually well tolerated as well as effective.
le effects are generally limited to transient
owsiness; serious, therapy-interrupting
le effects are rare.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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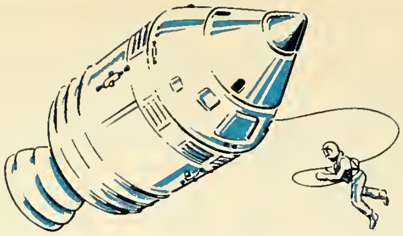

Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
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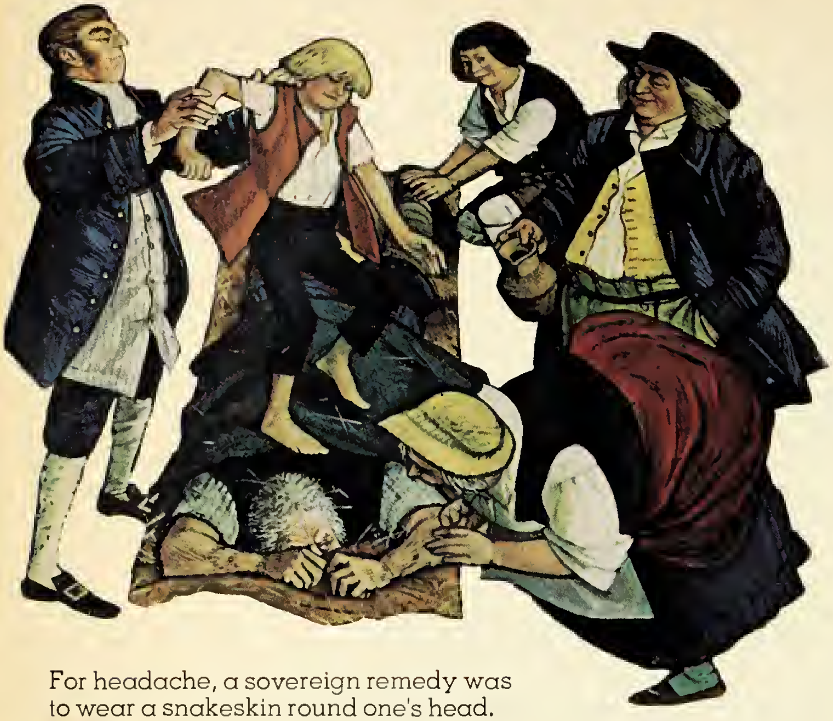
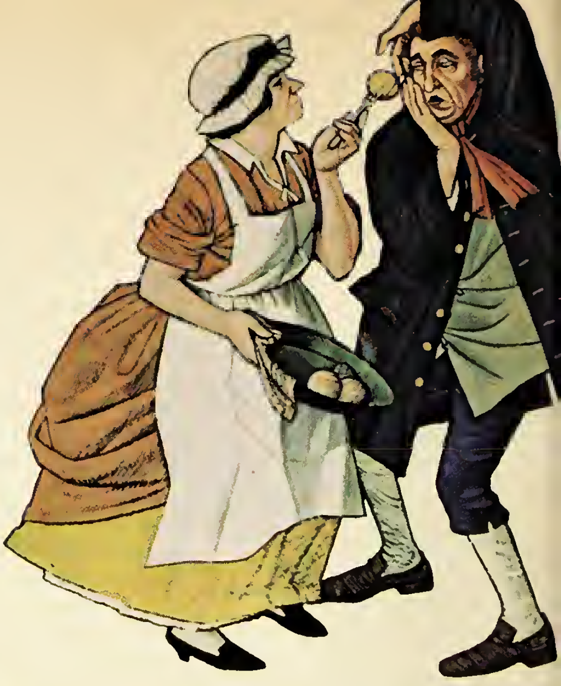
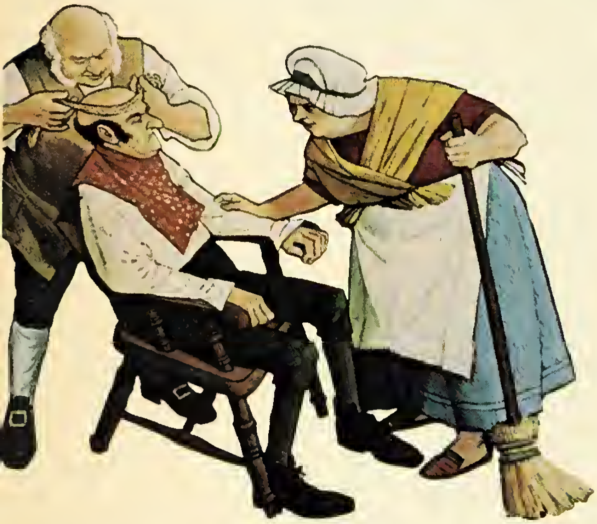
A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



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State Comprehensive Health Planning Spotlighted

BY HERBERT MEHLER
STAFF SECRETARY
MSMS COMMITTEE ON
GOVERNMENTAL-MEDICAL PROGRAMS

Because of the importance of and effect on the medical practitioner, this month's medical care programs page will be devoted exclusively to the activities and actions concerning State Comprehensive Health Planning.

PROCESS IN DEVELOPING AREAWIDE COUNCILS

You have previously received reports that the Battle Creek-Kalamazoo, Grand Rapids and Lansing areas have approved planning applications and funds. The Detroit Area grant application was approved and the formation of an areawide Council is now undergoing initial developmental steps. The Upper Peninsula Agency previously submitted a grant application but site visit problems resulted in disapproval. An organizational restructuring is now underway and there is movement toward a cohesive group with suggestions for proceeding.

In the Benton Harbor-St. Joseph Area organization is being carried out through a process jointly developed by the Health Facilities Planning Council and Ad Hoc Committee.

The Saginaw-Bay City Area has held an organizational meeting and a steering committee is meeting regularly to deal with the problems of internal structure.

An initial general meeting to organize was recently held for the Northern Michigan Area comprising of 18 counties.

The Flint region has had some preliminary meetings and has employed staff to guide organizational efforts.

An organizational meeting was held in the Jackson Region and the Muskegon Sub-Region is in the process of deciding approaches to the organization of that three-county area.

RECOMMENDATIONS OF THE TASK FORCE ON HEALTH CARE COSTS AND THE ORGANIZATION OF SERVICE

1. That the Commission and Advisory Council request Blue Cross and Blue Shield to review present reimbursement patterns to determine ways in which incentives might be developed to encourage use of alternatives to in-patient care.
2. A possible recommendation to the Michigan Hospital Association for the development of cost and productivity monitoring mechanisms.
3. Legislation be drafted to require health service rates be negotiated by Blue Cross with its participating institutions and by the State with its vendors. Such legislation should include specifications forbidding hospital employees, officers, trustees serving as members of Blue Cross policy making organizations.
4. Legislation be drafted to require health insurance sold to residents of the State cover the full range of health services.
5. The Advisory Council, as a back-up position, recommend that a State Health Insurance Corporation be formed which would be prepared to sell a full range of health insurance.
6. Study the costs and possible effects of various approaches and specifications required by the above preceding recommendations.

FRANCHISING

The Advisory Council has recommended franchising of local health care facilities — to include privately operated nursing homes. This means that areawide health planning agencies would be empowered to approve or disapprove any developmental proposal by a health care facility in a geographical area; and that a health facility could not be constructed without approval of the local agency including mental health facilities licensed or operated by the Department of Mental Health, neighborhood health centers, other organized outpatient services and county medical care facilities. Offices for the private practice of medicine or dentistry are not included under the Health Facilities Development Act now being considered for possible legislative introduction.

The MSMS Committee on Governmental Medical Care Programs reviewed this franchising matter and will recommend that the MSMS Council voice objection to appropriate state officials. This objection conforms with MSMS policy in December, 1965 that "(a) The Council does not approve of unlimited government franchising of hospital-related facilities; (b) The Michigan State Medical Society will continue to review with interest any well-thought-out proposal for directing the location of hospitals and related facilities in areas where they can provide care with reasonable economy and (c) proper professional participation is important and mandatory in all such planning especially from the Michigan State Medical Society."

NEW EXECUTIVE ORDER

(On this page you will find a brief resume of Governor Milliken's Executive Order 1970-1 that revises and modifies the structure of Comprehensive Health Planning in Michigan. Copies are available by writing MSMS.)

Governor Milliken has agreed with MSMS that an appeal mechanism is necessary in order that local planning groups can appeal unfavorable decisions of areawide planning councils. In his Executive Order 1970-1 the State Advisory Council shall adopt the following appeal procedure.

"1. Any public or private agency, organization or facility aggrieved by the action of an areawide comprehensive health planning agency or by the action of the state and having exhausted local procedures may request a hearing before the Advisory Council on Comprehensive State Health Planning.

"2. The Advisory Council shall establish reasonable procedures for such hearings in accordance with Act 88, The Public Acts of 1943, as amended. The Chairman of the Advisory Council may refer requests for hearings to a committee of the Council or to such other state advisory council as may be appropriate."

GOV. MILLIKEN CREATES NEW STATE OFFICE OF HEALTH PLANNING

Gov. William G. Milliken, by executive order, has created a new Office of Comprehensive Health Planning to work with the Comprehensive State Health Planning commission in its responsibility of providing long-range, interdepartmental health planning advice to the governor.

Elena Padilla, Ph.D., deputy director of the Comprehensive Health Planning Commission since July, is acting director of the new Office of Comprehensive Health Planning, until a permanent director is found.

The director of the office is to serve "at the pleasure of the Governor and report to the Governor's Executive Assistant for policies and programs," according to the order.

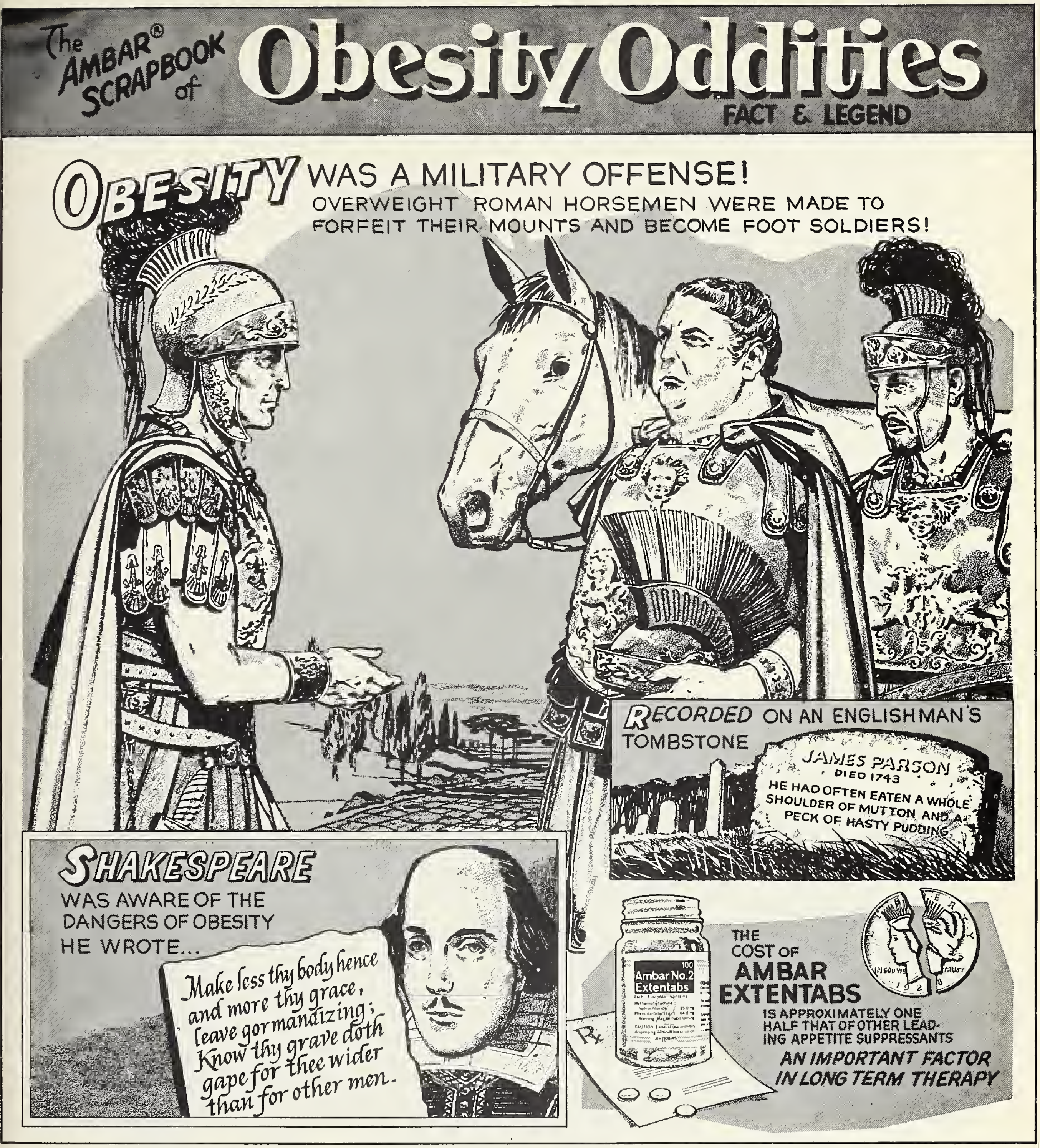
Responsibilities of the new office will be to make application for federal funds; present an annual audit and report; to review health planning efforts among governmental and nongovernmental groups concerned with health services, facilities and health manpower; establish policies and procedures for the expenditure of public funds for the purpose of comprehensive state health planning for both public and private health services; designate public or private nonprofit agencies for the purpose of area-wide health planning and approve project grants to them, and to review all the plans and programs of state departments and agencies relating to the provision of health services.

NEW MICHIGAN ASSOCIATION UNITES COUNTY HEALTH BOARDS

Boards of health in Michigan have united under a single banner with the founding of the Michigan Association of Boards of Health, taking in county health board representatives from all Michigan counties.

At the organization meeting in Lansing in December, members agreed on the basic purposes: (1) to establish and maintain communication and coordination between boards of health; (2) to plan orientation and training sessions for members of boards of health; (3) to provide a united effort for support from state, federal and other financial sources; (4) to analyze directives and proposed legislation affecting public health, and (5) to bring the views of boards of health to the attention of legislators and proper committees.

Officers elected to govern the organization in its first year are R. Myron Ross, M.D., Menominee, president, representing the Delta-Menominee county health district; Raymond Seguin, Macomb county, vice president; Mrs. Charlotte L. Williams, Genesee county, secretary, and Raymond H. Vanderlaan, Ottawa county, treasurer.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county societies

BERRIEN PHYSICIANS, ASSISTANTS HOLD JOINT MEETING

The Berrien County Medical Society and the Berrien County Medical Assistants Society met jointly in January to view a film dealing with medico-legal problems that may result from the conduct of medical assistants. The film was obtained through the efforts of Mrs. Joseph Van Dam, vice president of the Medical Assistants Society.

WASHTENAW DOCTORS HOST SHERIFF, SCHOOL LEADERS

Because of the physician's concern with nonmedical, as well as medical, community problems, members of the Washtenaw County Medical Socie-

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ACademy 7-1211

(A 16-m.m. sound color film on Brighton Hospital is available for free loan to qualified groups.)

ty invited their Sheriff, Douglas Harvey, to speak about the proper methods of law enforcement under various conditions and for different offenses. Sheriff Harvey was a guest at the medical society's January meeting.

PEPTIC DISEASE DISCUSSED BEFORE MACOMB PHYSICIANS

"Changing Concepts in Peptic Disease" was the topic of Richard O. Kraft, M.D., of St. Joseph's Mercy Hospital, Ann Arbor, when he spoke before the Macomb County Medical Society. Doctor Kraft was a guest of the Macomb physicians at their January meeting.

SAGINAW DOCTORS HEAR OF VASCULAR INJURIES

Members of the Saginaw County Medical Society heard Roger F. Smith, M.D., of Henry Ford Hospital, Detroit, discuss Vascular Injuries at their January meeting.

ENVIRONMENTAL DEGRADATION TOPIC OF KALAMAZOO MEETING

H. Lewis Batts, Jr., executive director of the Kalamazoo Nature Center, discussed Environmental Degradation at the January meeting of the Kalamazoo Academy of Medicine. Dr. Batts is president of the Kalamazoo County Park and Recreation Commission and a member of the board of national and state conservation organizations.

Kalamazoo County Physician/Population Ratio Improves

The physician-to-population ratio in Kalamazoo County has improved since 1935, reports Roscoe Hildreth, M.D., member of the Kalamazoo Academy of Medicine. Doctor Hildreth's figures show a 1969 ratio of one physician per 819 county residents, compared to one physician per 1,200 residents in 1935.

A further analysis of the applications for membership in the Academy since 1961 reveals that 10 new members of the academy in that time were returning home town boys, 51 were former Michigan residents, 28 were residents of other states and 16 were residents of foreign countries.

Fifty-one new Academy members were graduates of Michigan medical schools, 28 were graduates of schools in other states and 16 were graduates of foreign medical schools.

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DOCTORS — Munising, Michigan, has a drawing area of 10,000 people with its excellent schools, best water sports, and hunting in the Great Lakes and a 35 bed modern hospital with an ICCU, physical therapy, inhalation therapy, and surgery. There is an opening for a general surgeon or general practitioner who would like to do some general practice and surgery and work with a young general practitioner. The offices are located next to the hospital. If interested, contact Neil Grossnickle, M.D., Sand Point Road, Munising, Michigan 49862.

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Index to Advertisers

Arch Laboratories 264
Breon Laboratories 207
Brighton Hospital 264
Bristol Laboratories 199
Brown Pharmaceuticals 242
Burroughs Wellcome & Co. 260
Campbell Soup Co. 247
Classified Ads 266, 267
Fisher Bldg., The 243
Hynson, Westcott & Dunning 195
Lederle Laboratories 196, 259
Lilly, Eli & Co. 208
Mead Johnson Laboratories 234, 235, 252, 253, 270, 271
Medical Protective Co. 265
Merck, Sharp and Dohme 202, 203, 204
Mercywood Hospital 233
National Drug Co. .... Cover II, 237, 238
Parke-Davis & Co. 250, 255
Plainwell Sanitarium 239
Poythress, Wm. P. 258
Professional Management 241
Robins, A. H. & Co. 231, 232, 263
Roche Laboratories .... Cover IV
Searle, G.D. & Co. 248, 249
Stratton, Ben P. .... Cover III
Stuart Co., The 245
Wyeth Laboratories 256, 257

in memoriam

Doctor Scott, Former WSU Dean, Remembered with Memorial Services

Memorial services were held Feb. 25 at Wayne State University for Gordon H. Scott, Ph.D., WSU vice president for medical school development until his retirement in 1968. Doctor Scott died Jan. 30 in New York City at the age of 68.

Doctor Scott

Doctor Scott, dean of the WSU School of Medicine from 1950 to 1961, was builder of the first electron microscope for biologic research in the U.S. He was instrumental in the development of the Detroit Medical Center and was nationally known as a pioneer in medical education.

The Faculty Senate of the WSU School of Medicine has recommended that the new basic science instructional facility being built in the Detroit Medical Center be named the Gordon H. Scott Building, in recognition of his "untiring leadership and long service to the University and the Detroit community." Doctor Scott was named acting dean of the WSU School of Medicine in 1948, dean in 1950 and vice president of medical school development in 1961.

He was the recipient of the WSU School of Medicine's Distinguished Service Award in 1964, as well as the 1958 Regents Outstanding Achievement Medal of the University of Minnesota, from which he received his Ph.D.

He was an honorary member of MSMS.

Ernest H. Beernink, M.D.
Grand Haven

Ernest Henry Beernink, M.D., retired Grand Haven physician, died Jan. 3 at the age of 75.

Doctor Beernink, a general practitioner in Grand Haven for 39 years, retired in 1965. He was past president of the Ottawa County Medical Society, former chief of staff at North Ottawa Community Hospital and has been affiliated with Grand Haven Municipal Hospital. He was a graduate of the University of Michigan School of Medicine.

Charles L. Boseman, M.D.
Ypsilanti

Charles L. Boseman, M.D., chief of the outpatient department of the Ann Arbor Veterans Administration Hospital, died in a fire in his home on Dec. 25. He was 46.

Doctor Boseman was a graduate of the University of Michigan School of Medicine and had served on the Ypsilanti Human Relations Commission.

Edward W. Douglas, M.D.
Jackson

Edward W. Douglas, retired Southern Michigan Prison doctor, died Jan. 14, 1970, at the age of 84.

Doctor Douglas served from 1949 to 1958 as full-time physician at the prison, and then moved to New Kensington, Pa., where he was an emergency room physician in the Citizens General Hospital until his retirement in 1965. He had since returned to Jackson.

Doctor Douglas was a graduate of the University of Pittsburgh School of Medicine, a life member of MSMS, and past president of the Wayne County Medical Society.

Arthur D. Harris, M.D.
Detroit

Arthur Drayton Harris, M.D., 59-year-old Detroit obstetrician-gynecologist, was shot and killed by four Detroit youths Jan. 30 across the street from his west side office.

One of Detroit's most loved, respected and dedicated black physicians, Doctor Harris had served his community in activities as diverse as Little League and deputy director of the Medical Division of the Mayor's Committee for Human Resources Development.

Doctor Harris was a member of the MSMS Committee on Maternal and Perinatal Health from 1961 to his death and had been a member of the Wayne County Medical Society Committee on Maternal Deaths. He was also founder and chairman of the Clinic Day Program of the Detroit Medical Society from 1957-1963.

Doctor Harris, a graduate of the Wayne State University School of Medicine, was affiliated with Crittenton, Grace and Boulevard General Hospitals in Detroit and was chief of staff of the Comprehensive Neighborhood Health Service Center at Herman Kiefer Hospital.

Frank D. Johnson, M.D.
Flint

Frank D. Johnson, M.D., Flint internist who was a member of the MSMS Rheumatic Fever Control Committee for 10 years, died Jan. 13 at the age of 70.

Doctor Johnson was former chief of medicine at St. Joseph Hospital in Flint and past president of the Genesee County Medical Society. He had also served as a delegate to the MSMS House of Delegates from Genesee County from 1949 to 1961.

Doctor Johnson was a graduate of the University of Michigan School of Medicine and had practiced medicine in Flint since 1926. He was director of medical education at St. Joseph Hospital there from 1967 until his death, and was also affiliated with Hurley and McLaren General Hospitals in Flint. In 1964, St. Joseph's interns and residents cited Doctor Johnson as the "Outstanding Clinical Instructor of the Year."

Doctor Johnson had been health officer for the City of Flint and Genesee County Coroner. He was a member of the Michigan Heart Association and the Michigan Diabetes Association, was a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians.

Napoleon F. LaFrance, M.D.
Cooper City, Fla.

Napoleon Francis LaFrance, M.D., former staff physician with the Battle Creek Veterans Administration Hospital, died Jan. 21 in Hollywood, Fla., at the age of 68.

Doctor LaFrance, who held the Battle Creek post from 1951 to 1964, transferred to the Augusta, Ga., VA Hospital in 1964 and remained there until his retirement in 1969, when he and Mrs. LaFrance moved to Cooper City, Fla.

He was a graduate of St. Louis University School of Medicine and was in private practice in Battle Creek from 1932 to 1951. He was a member of the American Psychiatric Association and the Michigan Society of Psychiatry and Neurology.

Harry C. Metzger, M.D.
Huntington Woods

Harry C. Metzger, M.D., retired Detroit pediatrician, died Jan. 13 at the age of 68.

Doctor Metzger had been a physician with the Wayne State University Student Health Service and was affiliated with Children's Hospital of Michigan in Detroit.

He was a graduate of the University of Michigan School of Medicine and was a diplomate of the American Board of Pediatrics. He was a fellow of the American College of Chest Physicians.

James M. Stanton, M.D.
Royal Oak

James M. Stanton, former head of the psychiatric department of Detroit General Hospital, died Jan. 5 at the age of 74.

Doctor Stanton, who practiced in Detroit for 47 years, was a diplomate of the American Psychiatric Association and a life member of the American Psychoanalytical Association.

He was a graduate of the University of Michigan School of Medicine.

J. Marion Sutherland, M.D.
Detroit

J. Marion Sutherland, M.D., retired Detroit otolaryngologist, died Dec. 22 at the age of 87.

Doctor Sutherland, who retired in 1962, was past president of the Detroit Otolaryngological Society and past vice president of the Middle Section of the American Laryngological, Rhinological and Otological Society. He had been affiliated with Harper Hospital.

Doctor Sutherland held medical degrees from the University of Illinois School of Medicine and the medical department of the University of Vienna. He had been assistant professor at Wayne State University School of Medicine.

Edward M. Vardon, M.D.
Highland Park

Edward M. Vardon, M.D., Highland Park surgeon, died Jan. 21 at the age of 72.

Doctor Vardon was a graduate of the Detroit College of Medicine and was chairman of the Highland Park General Hospital's surgical service.

Doctor Vardon had been a delegate to the MSMS House of Delegates and a member of the Board of Trustees of the Wayne County Medical Society, as well as chairman of the WCMS Committee on Nursing. He was past president of the Wayne University Medical Alumni and Board of Governors.

He was a diplomate of the American Board of Abdominal Surgeons, a fellow of the American College of Surgeons and the International College of Surgeons, and a member of the American Academy of Surgery, the Detroit Surgical Society, and the Association of American Physicians and Surgeons.

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they need the proved effectiveness and safety of

K·LYTE®

Each effervescent tablet supplies: 2.5 Gm. potassium bicarbonate (25 mEq. elemental potassium), 2.1 Gm. citric acid, cyclamic acid

Three clinical studies* confirm the effectiveness of good tasting K-Lyte as a source of supplemental potassium to increase low levels of serum potassium and to maintain normal levels. Patients were on continuous diuretic therapy and salt-restricted diets. K-Lyte dosage was one tablet b.i.d.

Serum Potassium Levels (in mEq./L)

Number of patients	Mean initial value	Mean final value
14	3.23	4.83
16	3.50	4.40
25	4.52	4.47

K-Lyte can offer effective potassium supplementation without the gastrointestinal complications sometimes associated with potassium chloride tablets and thiazide-potassium chloride combination therapy. Effervescent K-Lyte is taken in solution, speeding up absorption to avoid these hazards.

Composition: Each tablet contains potassium bicarbonate (2.5 Gm.), citric acid (2.1 Gm.), cyclamic acid, artificial flavor and color.
Contraindications: When renal function is impaired, or if the patient has Addison's disease, potassium supplementation should not ordinarily be instituted.
Precautions: Should not be used in patients with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations.
Side Effects: While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum.
Administration and Dosage: K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement.
How Supplied: Effervescent tablets—boxes of 30 and 250 (orange or lime).

*Reports on file: Medical Research Department, Mead Johnson Laboratories, Evansville, Indiana 47721

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BY HERB AUER, EXECUTIVE EDITOR

"Medical science has made a quantum leap in the past two decades," contends William H. Stewart, M.D., U.S. Surgeon General. He continued in one of his many recent addresses: Medical science in the past two decades "includes new vaccines that can eradicate ancient scourges; a remarkable battery of new drugs; brilliant advances in surgical techniques; new diagnostic tools; development of artificial organs, machines that perform organic functions, organ transplantation; and many more. We are beginning to harness the awesome potential of the electronic computer to medical purposes. We have made rapid progress in the technology of birth control. We have unlocked many of the secrets of the genetic code. We are making important voyages of discovery in the most complex of all challenges, the understanding of the human mind."

* * *

Recently Newspaper Columnist Sydney J. Harris wrote:

"The very success of capitalism, resulting in its high productivity, has undermined the position of the middle classes, by making more goods available to more people, and by raising the wages of the "proletariat" to a point where factory employment is far preferable to domestic employment — and where craftsmen like plumbers and carpenters charge through the nose for doing jobs poorly that used to be done well.

"We are puzzled and irritated by these changes in the social pattern, and prefer to blame them on "radical" or "revolutionary" doctrines, when in point of fact they are the perfectly natural result of a high-productivity culture which is continually erasing the differences between city and county, North and South, bourgeoisie and worker."

* * *

A recent issue of *Marketing/Communications* magazine for the advertising industry reports on the growing activities by advertising firms to place messages on TV to urge physicians to prescribe their pharmaceutical products. The article includes such comments as "The detail man has become less important as there are fewer new products" and that firms are going to TV advertising to supplement the detail men, the messages in medical journals, etc.

The article looks to the future with this comment: "A question is whether the presence of more hard sell (to doctors,) more non-scientific sell, or more cute sell is going to eventually bring firmer restrictions from the FDA." One advertising executive is quoted in the article as saying that he "believes that abuse of consumer concepts is already at an irritating level in medical ads and could eventually force the FDA's hand."

* * *

A statement which is, in effect, a blow at chiropractic has been approved by the Health Insurance Council and the Health Insurance Association of America. Entitled "Limited Practitioners," the statement stresses the importance of education in determining the role limited practitioners should play in the organization and delivery of medical care. It supports "the concept that the providers of health care should base such care on scientifically-established methods of diagnosis and treatment." The statement points to the need for "adequate initial and continuing education and training . . . conducted in institutions that are accredited by recognized educational accrediting agencies."

* * *

UCLA recently published a report, *A Study of a Profession and Professional Education,* which contends that the professional "is Client-oriented."

In part, the study states, the fallacy of professional endeavor "lives in the assumption that the professional, who is trained to solve social problems — and he is the only one educated to solve them — will automatically and knowingly determine the full social consequences of his decisions and act unselfishly in the greater public interest. This is simply not the case. The professional does not now assume responsibility for society, nor has he been educated to anticipate the social consequences of his decisions.

"In reality, the professional is Client-oriented. He recognizes his responsibility to his client, but these are individual matters, and he has not been prepared to consider larger implications. Collectively, the social visibility of national professional societies has not proven significantly better."

* * *

Ralph Rabinovitz, M.D., director of Hawthorne Children's Center, in discussing the use of drugs by youths, has called on the medical profession to consider whether certain drugs such as amphetamines should cease to be manufactured at all since their medical need and use is so small.

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**All MSMS Members Invited
To Annual MSMS Conference on
Medical Aspects of High School Sports
April 30 at Towsley Center, U-M**

FEATURES IN THIS ISSUE

Solitary Splenic Abscess
Granulocytic Leukemia in Pregnancy
Is Medical Care a Right or a Privilege?

Michigan State Medical Society
April 1970, Volume 69, Number 7

MSMS 1970 Annual Session Dates: Sept. 20-24

The girth control pill

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Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. *Sympathomimetic cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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Breaking News
March 1970, Volume 69, Number 6
Michigan State Medical Society

michigan medicine

MSMS to Introduce Package of New Bills; Basic Science, Insurance, Liability Proposals Included

MSMS will introduce a "package" of bills into the 1970 session of the Michigan State Legislature, as authorized by The Council in late January.

Passage of one of the MSMS offerings would *exempt* any U. S.-trained MD and osteopath from meeting a Michigan "basic science" requirement before qualifying for a license to practice in Michigan. Foreign-trained physicians and chiropractors, however, would still have to meet "basic science" standards.

A second MSMS bill, aimed at improving the "professional liability climate," would guarantee the privacy of all records, data and knowledge of peer review committees. MSMS' third bill would limit the office of State Director of Public Health to a physician possessing scientific qualifications in preventive medicine.

MSMS also will seek a new statute to make professional liability insurance coverage more readily available for public health administrators, a clarifying amendment to the new law which permits minors to give their own consent for treatment for venereal disease (which will provide more adequate protection for physicians), and an amendment to ambulance laws to cover freedom from civil liability for doctors instructing ambulance personnel via radio. Finally, MSMS is sponsoring an amendment to the county hospital law so that it will no longer contain language discriminatory against women or physicians as trustees.

Doctor Engelke Seeks Post of AMA Vice President

Doctor Engelke

Among the physicians running for the national office of vice president of the American Medical Association is Otto K. Engelke, M.D., Ann Arbor, whose candidacy was announced March 2 by MSMS. The election of new AMA officers will take place in June.

A past president of MSMS and chairman of the Legal Affairs Committee, Doctor Engelke has long been a delegate from MSMS to the AMA. He has also been a member of both the Council on Environmental and Public Health and the Joint Committee on Environmental Health of the AMA and has served the past 29 years as director of the Washtenaw County Public Health Department.

Doctor Engelke has served as president of the Michigan Public Health Association, the Michigan Public Health Officers Association and the Michigan Health Council.

Dean Gardner, Associate Deans Walt and Levitt Resign at WSU School of Medicine

This news issue of *Michigan Medicine* was all locked up and ready to print March 16 when the newspapers broke the story in Detroit about the resignations of Medical School Dean Ernest D. Gardner, M.D.; Associate Dean Alexander Walt, and Associate Dean Morton Levitt, Ph.D. Dean Gardner was quoted as saying that the three would remain on the WSU faculty and that their resignations "are irrevocable."

Newspapers reported the resignations "and growing faculty discontent" were due to serious disagreement with WSU planners and administrators.

Additions to In Memoriam

Since the deadline for the March issue of *Michigan Medicine,* the following news has reached the MSMS office. Details will follow in future issues.

DeWitt T. Burton, M.D., Detroit, 77, died Feb. 17.
Harold F. Closz, M.D., Muskegon, 79, died Feb. 13.
Gilbert R. DeRyke, M.D., Livonia, 55, died Jan. 22.
Fred J. Drolett, M.D., Lansing, 91, died Feb. 18.
William J. Kofmehl, M.D., Stambaugh, 82, died Jan. 10.
Paul Van Riper, M.D., Champion, 94, died Feb. 16.
William A. Mudge, M.D., Negaunee, 84, died Jan. 28.
L. Warren Gatley, M.D., Birmingham, 69, died Jan. 26.
D. H. Kaump, M.D., Ann Arbor, 62, died Feb. 13.

County Societies and MSMS Councilors May Nominate MMS Board Members Until April 15

County medical societies, as well as MSMS councilors, are invited to submit names for nomination to the board of Michigan Medical Service before April 15, according to Resolution 84 from the 1969 House of Delegates meeting.

James B. Blodgett, M.D., speaker of the House, has asked that nominations be made as early as possible, to make the names and qualifications of the final nominees known to the House of Delegates well in advance of the 1970 meeting.

Medicine-Religion Meeting Planned April 1 in Detroit By MSMS, Wayne County Medical Society

The Rev. Westburg

"A physician knows what faith can do in the total health care of a patient. Often, in dark moments, it becomes as powerful as the most potent vaccines . . . as impressive as the instruments of modern medicine, in restoring the blessings of health" . . . (from AMA release)

The relationship of faith and medicine will be the topic when MSMS and the Wayne County Medical Society sponsor a Medicine and Religion meeting April 1 at WCMS Headquarters, Detroit, for members of county medical societies' committees on medicine and religion and their clergymen.

Featured speaker will be the Rev. Granger E. Westburg of the Hamma School of Theology, Wittenberg University, who will discuss "Good Grief." A panel on grief crises and an afternoon workshop on medicine-religion programs for county medical societies also are planned.

MSMS PRESIDENT Robert J. Mason, M.D., Birmingham, at head of table, is making a series of informal visits with the leaders of county medical societies around the state for discussion of current objectives of organized medicine. At a recent meeting with Saginaw County Medical Society leaders, he talked with, from left, John Finger, M.D., county bulletin editor; Carl Stander, M.D., MSMS councilor; Hugh W. Brenneman, MSMS executive director; Roy Gerard, M.D., former Saginaw society president; Harry Matthews, current Saginaw president; Carl King, Saginaw executive director; V. V. Bass, M.D., MSMS vice speaker; Larry Bruggers, M.D., Saginaw president-elect, and Ralph Wills, MSMS director of community relations.

Michigan Heart Association's Heart Days May 7-9

The Michigan Heart Association will present its Heart Days and Scientific Sessions May 7-9 at Cobo Hall, Detroit. General theme of the Scientific Sessions beginning May 8, will be "Cardiology and Surgery—More Hope in the Seventies." Interested physicians may obtain further information from the Heart Association at 13100 Puritan, Detroit 48227.

New Orleans Saints Team Physician to Speak At 1970 MSMS Sports Conference at the U-M

The team physician for the New Orleans Saints football team will speak at the Annual Michigan Conference on the Medical Aspects of High School Sports April 30 at the University of Michigan Towsley Center, for coaches, team physicians, trainers and others interested in athletic medicine.

J. Kenneth Saer, M.D., an orthopedic surgeon in New Orleans, will discuss "Shoulder Injuries" and another topic on the all-day conference. Doctor Saer, who serves both the professional Saints, and the Tulane University teams, is no newcomer to Michigan because he did his orthopedic residency at the University of Michigan Medical School.

The 1970 Conference is being planned by the MSMS Committee on the Medical Aspects of Organized Athletics with Gerald O'Connor, M.D., chairman. A registration form appears below for easy use . . .

REGISTRATION FORM

Return to: CONFERENCE ON THE
MEDICAL ASPECTS OF HIGH SCHOOL SPORTS
Michigan State Medical Society
P.O. Box 152
East Lansing, Michigan 48823

NAME______________________________

ADDRESS______________________________

CITY______________________________

STATE________________ZIP____________

Please register me for the Conference April 30 and the luncheon. I understand that the sponsors will cover program costs, and that I will be charged for the luncheon.

DO NOT SEND MONEY WITH THIS FORM

John R. Pedden, M.D., standing, Grand Rapids councilor, presided at a recent meeting at MSMS to advance plans for possible physician assistant courses at Michigan colleges. Doctor Pedden is chairman of the MSMS Education Liaison Committee which is encouraging and assisting several colleges, and which has reported progress each year to the MSMS House of Delegates.

William Birch, M.D., standing, Kalamazoo, who introduced the first MSMS resolution to explore the physician assistant idea, is chairman now of the Subcommittee on the Physician Assistant. Here he is introducing T. F. Zimmerman, Ph.D., director of the AMA Department of Health Manpower, who came to visit with Michigan physicians, educators, government officials about the AMA efforts.

New Hormone Topic of Beaumont Lecture April 6

Doctor Copp

The annual Beaumont Lecture of the Wayne County Medical Society will be given April 6 by D. Harold Copp, M.D., professor of physiology of the University of British Columbia. His subject will be "Calcitonin — A New Hormone Involved in Calcium Regulation and Bone Metabolism." Calcitonin, produced by the glands of internal secretion, was discovered by Doctor Copp.

The 8 p.m. lecture in the WCMS Auditorium will follow a dinner in honor of Doctor Copp.

C. R. Lam, M.D., Detroit, is chairman of the Beaumont Lecture Committee. The Beaumont Lectures have been given annually since 1922, honoring William Beaumont, M.D. (1785-1853), the Army surgeon at the fort on Mackinac Island who made the first important studies of the physiology of digestion.

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MICHIGAN STATE MEDICAL SOCIETY

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Breaking News: Deadline March 24
April 1970, Volume 69, Number 7
Michigan State Medical Society

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Acting Dean To Be Named For Wayne State University School of Medicine

As this issue went to press, Wayne State University's President William R. Keast was expected at any time to name an acting dean of the Medical School.

On March 23, President Keast proposed the appointment of a task force on medical school programs and development to begin work immediately and to be headed by the acting dean. He also proposed a search committee to recommend a new dean for the school and another search committee for a new vice president for health affairs.

President Keast made it clear that he did not intend to keep Ernest Gardner, M.D., the medical dean who announced his resignation March 18, in an administrative position. Two other medical deans, Alexander J. Walt, M.D., and Morton Levitt, Ph.D., resigned with Doctor Gardner.

Keast said he agreed with medical school personnel that the new dean should be a physician with broad experience in academic medicine. The student body of the medical school has requested that Doctor Gardner be named to the new health vice presidency.

Doctor Moses Seeks AMA Council Post

Doctor Moses

John W. Moses, M.D., Detroit, ex officio member of The MSMS Council, scientific editor of *Michigan Medicine* and director of medical education at Mt. Carmel-Mercy Hospital, Detroit, is running for a seat on the AMA Council on Medical Education.

Doctor Moses' candidacy for an AMA post is the second of a Michigan doctor to be announced by MSMS. Otto K. Engelke, M.D., Ann Arbor, is seeking the position of AMA vice president. Elections will take place at the national convention in Chicago in June.

Doctor Moses, an internist, is a clinical instructor at Wayne State University School of Medicine, is an advisor to the MSMS Postgraduate Medical Education Committee and is an alternate MSMS delegate to the AMA. He is a member of numerous national specialty groups.

Basic Science Amendment Seen Possible in 1970

MSMS' physician volunteers who have been devoting a week to observing the Lansing capitol scene report growing acceptance of the proposal that the provisions of the 1937 Basic Science Act no longer apply to medical and osteopathic physicians who have received their degrees in U.S. schools.

Under the proposed amendment, chiropractors and all MDs or DOs trained in foreign countries would still be required to pass Basic Science tests (or meet this requirement by reciprocity) before being eligible for licenses from their own boards.

For several years unsuccessful attempts have been made to completely eliminate the 33-year old Basic Science statute. For the last two years the repeal bill has been sponsored by the Administration, and this year the Mental Health Department has joined a long list of groups pointing out the deterrent this test presents to the recruitment of badly needed physicians.

The Basic Science amendment bill is designated HB 4059 and is before the House Public Health Committee, Rep. William Fitzgerald (D-Detroit) Chairman. MSMS points out that the amendment would make a significant improvement in the ability of Michigan to attract needed physicians, and urges members to contact their own State Representatives and particularly the following members of the House Public Health Committee:

Rep. Stanley Davis (D-Grand Rapids), Rep. Daniel Cooper (D-Oak Park), Rep. Mrs. Lucille McCollough (D-Dearborn), Rep. Mrs. Joyce Symons (D-Allen Park), Rep. Dale Warner (R-Eaton Rapids), Rep. Richard Allen (R-Ithaca), Rep. Bert Brennan (R-Saginaw) and Rep. Edson Root (R-Bangor).

Michigan Team Physicians, Coaches, Trainers Invited to Conference on Sports-Medicine April 30

A top Michigan high school athletic trainer and the head athletic trainer at Purdue University will speak at the 1970 Conference on the Medical Aspects of High School Sports April 30 at Towsley Center, the U-M.

Walt Kanicki, trainer at Bay City's Central High School, and William

---

MEMBERS OF the MSMS Committee on Mental Health held a recent meeting especially to talk with members of the Michigan Legislature who serve on House and Senate committees interested in mental health problems. Benjamin Jeffries, M.D., Harper Woods, center, MSMS Mental Health Committee chairman, talked informally before the meeting with Rep. Peter Kok of Grand Rapids, left, and Sen. Arthur Cartwright of Detroit.

OTHERS ATTENDING the Mental Health Committee's meeting with Michigan legislators were, from left, William H. Anderson, M.D., Lansing, director of the Michigan Department of Mental Health and an advisor to the MSMS committee; Rep. James Tierney of Garden City, center, and Edward H. Rodda, M.D., Bay City, vice chairman of the Mental Health Committee.

"Pinky" Newell, R.P.T., head trainer, Purdue, and former executive secretary of the National Athletic Trainers Association, will appear at the annual event sponsored by the MSMS Committee on the Medical Aspects of Organized Athletics.

Gerald O'Connor, M.D., Ann Arbor, is conference chairman. Interested physicians may contact MSMS headquarters for further information.

MSMS To Co-Sponsor April 25 Health Careers Forum for Detroit Youth

Estimates are that 2,000 youngsters will attend a day-long Health Careers Forum April 25 at the Rackham Building in downtown Detroit. The event will be sponsored by the Wayne County Medical Society, Michigan State Medical Society, Michigan Health Council, *Detroit News* and several related groups, in conjunction with the Science Fairs being held earlier in the month by the *Detroit News.*

The winners of four Science Fairs planned earlier in April by the *Detroit News* will display their exhibits at the forum. They will be invited to a special luncheon the day of the forum by MSMS.

Interested students and their parents will be invited to two health careers programs at the building at 10 a.m. and 2 p.m. Coupons for free tickets to the forum will be printed in the *Detroit News.*

MSMS Members Urged to Attend PG Clinics; All for First Time to Include Wet Clinics

All MSMS-sponsored Postgraduate Clinics during spring, 1970, will include for the first time, an afternoon wet clinic, to be followed by a dinner and evening lecture by a visiting physician. Again, Michigan's three medical schools and the Michigan Department of Public Health will cooperate with MSMS in presenting the clinics.

Following is the Spring Schedule:

LOWER PENINSULA

Alpena, 4 p.m., Thursday, April 9
Battle Creek, 3 p.m., Tuesday, May 5
Cadillac, 3:30 p.m., Thursday, May 21
Grand Haven, 4 p.m., Friday, April 10
Grayling, 4 p.m., Wednesday, May 6
Howell, 4 p.m., Wednesday, May 13
Midland, 2 p.m., Thursday, May 14
Muskegon, 1:30 p.m., Wednesday, May 20
Petoskey, 4 p.m., Thursday, May 21
St. Joseph, 3:30 p.m., Tuesday, May 26

UPPER PENINSULA

Escanaba, 2 p.m., Tuesday, May 19
Houghton, 3:30 p.m., Monday, May 18
Iron Mountain, 2:30 p.m., Wednesday, May 20
Ironwood, 3:30 p.m., Tuesday, May 19
Menominee, 3:30 p.m., Wednesday, May 20
Sault Ste. Marie, 3:30 p.m., Monday, May 18

Blue Cross and Blue Shield Announce Rate Increase for Doctors' Group

In a letter to subscribers in the doctors' group last week, Blue Cross-Blue Shield announced a substantial increase in rates for the period beginning May 1, 1970.

The semi-private for 1969, full-family, was $37.90; in 1970 it will be $49.56 monthly. The two person semi-private contract in 1969 was $39.65; in 1970 it will be $45.84. The Blue Cross-Blue Shield announcement says that under the merit rating system the primary influence on the group rate is the utilization of contract benefits by the enrolled members.

The announcement also gave some experience figures on income and payout for a twelve month period, November 1968 to October 1969, as follows:

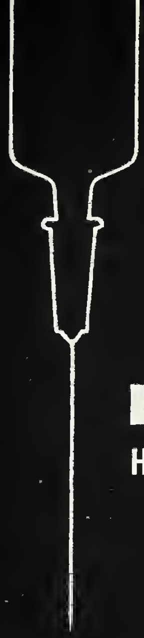
Blue Cross Income	$1,124,446
Blue Cross Claims	1,145,447
Negative Balance	$ 21,001
Blue Shield Income	$ 664,419
Blue Shield Claims	839,141
Negative Balance	$ 174,722

The report said, "A significant portion of the Blue Cross and Blue Shield payments indicated is the result of the continued rise in health care costs. The above figures do not include required expenses necessary to administer the program."

These rate increases are similar to those for other professional associations with similar benefit programs.

A SPECIAL one-hour program, "Formula for the Pill," was presented recently over WJIM-TV, Lansing, by Hugh W. Brenneman, left, executive director of MSMS and the Michigan Association of the Professions. Among the experts called in to discuss the facts and fallacies of oral contraceptives were, from left, C. Alvin Paulsen, M.D., associate professor, University of Washington School of Medicine; S. J. Behrman, M.D., professor of Ob/Gyn at the University of Michigan and director of its Center for Research in Reproductive Biology; and Tommy N. Evans, chairman, Department of Ob/Gyn at Wayne State University.

SPECIALISTS CALLED to give their expert opinion during the discussion of The Pill on the Formula television program included, from left, Michael J. Brennan, M.D., Detroit, president of the Michigan Cancer Foundation; Raymond H. Kahn, Ph.D., professor of anatomy at the University of Michigan; Lorraine Beebe, Dearborn, Michigan senator; Joan C. Stryker, M.D., obstetrician and gynecologist and Lee B. Stevenson, M.D., Detroit, vice chairman of the MSMS Committee on Maternal and Perinatal Health.



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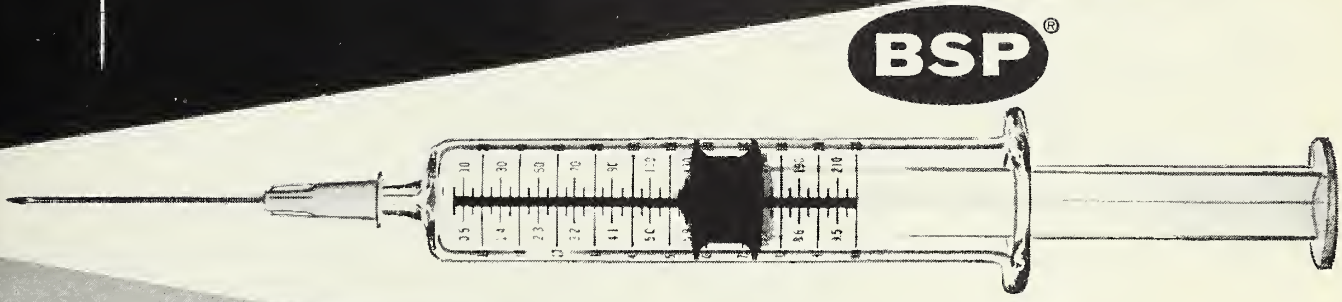

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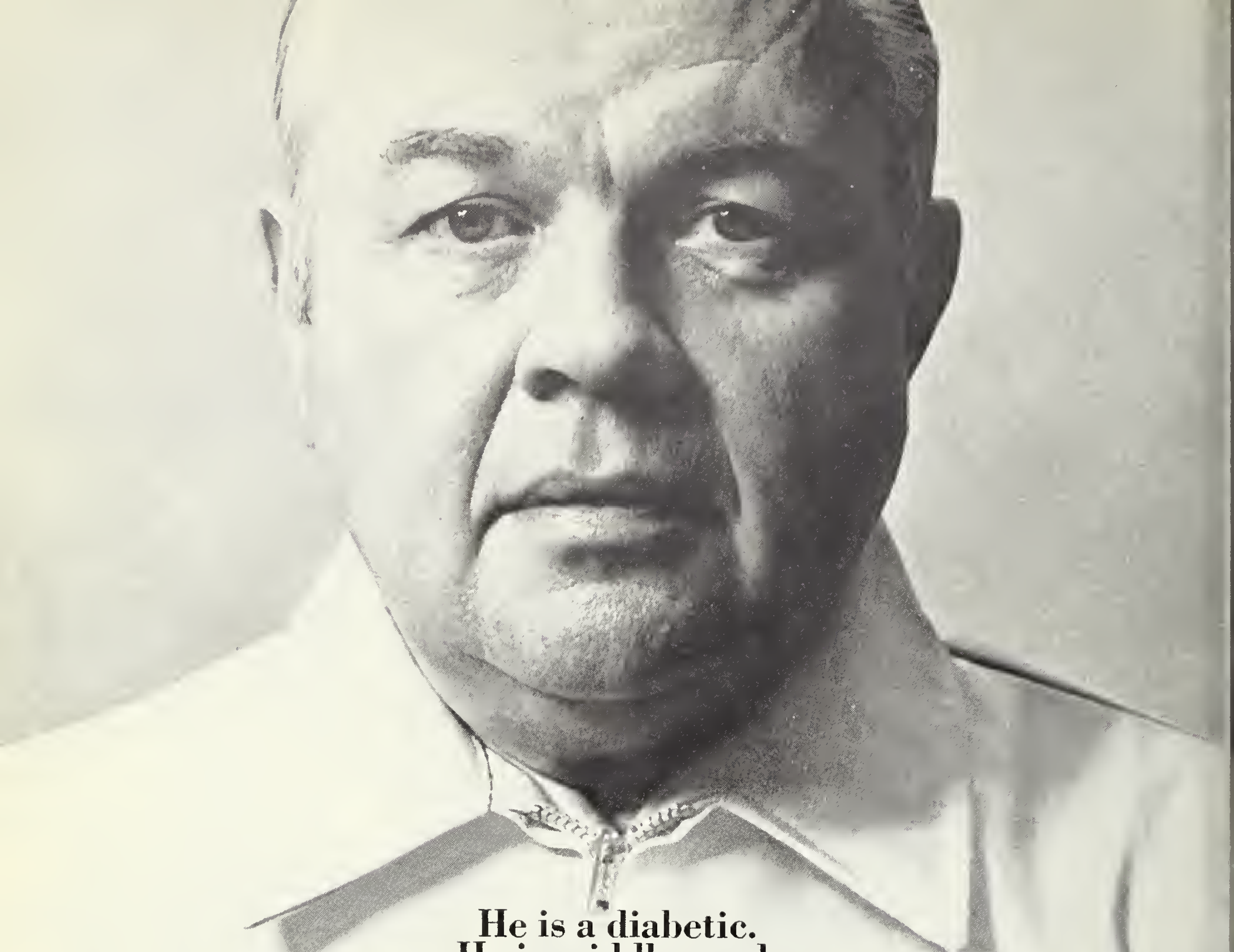

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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

IN THIS ISSUE

This month's cover design incorporates games symbols from the 1968 Summer Olympics in Mexico City. They are the symbols for track, tennis, swimming and weight-lifting, all of them a part of Michigan high school athletic programs and likely to be discussed at the April 30 MSMS Conference on the Medical Aspects of High School Sports.

SCIENTIFIC ARTICLES

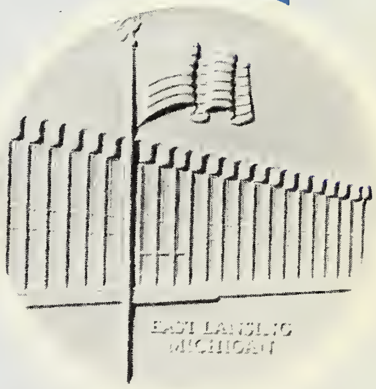
293 Solitary Splenic Abscess; Donald H. Kuiper, M.D.; John P. Papp, M.D.; Norman W. Thompson, M.D.
297 Granulocytic Leukemia in Pregnancy with Fetal Chromosomal Endoreduplication; J. Kadowaki, M.D.; K. S. Moghissi, M.D., F.A.C.O.G.; G. N. Loomus, M.D.
301 Cardiovascular Roentgenology; M. Viamonte, M.D.
305 A Health and Nutrition Study Among Michigan Indians; Walter C. Willet; Ralph A. Foulke; John R. K. Robson, M.D.; Walter D. Block, Ph.D.; Lawrence V. Perlman, M.D.

SPECIAL ARTICLES

304 Follow-up Underway on U.P. Health Studies
312 The AMA — Why Belong? Hugh H. Hussey, M.D.

OTHER FEATURES

284 about doctors
286 msms leadership
287 officers' page
288 your opinion please
290 county societies
296 monthly surveillance report
michigan authors
323 msms news
mediscene
324 council minutes
326 mailbag
336 new members
339 ancillary
345 medcial care programs
350 medicolegal
355 editorial viewpoints
362 in memoriam
366 noted and quoted



MICHIGAN STATE MEDICAL SOCIETY
120 West Saginaw (P.O. Box 152)
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about doctors

GEORGE H. AGATE, M.D., LANSING,
who retired recently from the State Department of Public Health as the epidemiologist, has accepted a similar post with the state health department of Illinois.

MARTIN F. BRUTON, M.D., DETROIT,
is the new medical director of the Chrysler Corporation after serving since 1958 as the assistant medical director. He has been with Chrysler since 1956.

MERVYN M. NICKELS, M.D., TRAVERSE CITY,
has retired as assistant superintendent at the Traverse City State Hospital. He joined the hospital staff in 1936 and was named assistant in 1946.

WILLIAM J. OLIVER, M.D., DETROIT,
recently was elected president of the Michigan Kidney Foundation. He is chairman of the U-M pediatrics department.

JOHN R. McDONALD, M.D., DETROIT,
is serving as a member of the Committee on Physicians of the American Hospital Association.

ROGER B. NELSON, M.D., ANN ARBOR,
is a member of the American Hospital Association Joint Committee with the American Society of Hospital Pharmacists.

ROBIN C. BUERKI, M.D., DETROIT,
is a representative of the American Hospital Association to the Advisory Board for Medical Specialists.

JULIEN PRIVER, M.D., DETROIT,
is a member of the American Hospital Association Council on Professional Services.

CRAIG BOOHER, M.D., GRAND RAPIDS,
is a member of the American Hospital Association Special Committee on Collective Bargaining.

JOHN H. KITCHEL, M.D., GRAND HAVEN,
was chairman of a major state-wide citizens' workshop on environmental control March 5 in Lansing. The conference began with an address by Gov. William G. Milliken, and included discussions of water quality, land use planning, air quality and maintaining or restoring quality in the environment. Doctor Kitchel is also president of the Michigan United Conservation Clubs, one of the sponsors of the workshop.

OTTO O. BECK, M.D., BIRMINGHAM,
a past president of MSMS and tireless worker for Beaumont Memorial on Mackinac Island, has announced his retirement after more than a third of a century of distinguished service.

LELAND E. HOLLY, II, M.D., MUSKEGON,
has been named head of the Muskegon Area Development Council's 1970 membership drive. Doctor Holly will control recruitment of campaign workers and their training.

ROBERT G. COMBS, M.D., LANSING,
discussed "Tubular Stainless Steel Mesh in Surgery of the Hand — A Preliminary Report" at the annual meeting of the American Society for Surgery of the Hand in Chicago.

JOHN R. RODGER, M.D., BELLAIRE,
has served approximately 25 years on state councils to administer Hill-Burton funds. He is currently serving a four-year term on the State Health Facilities Council, which was reorganized in 1968 under the Hospital Licensing Act from the former State Health Facilities Advisory Council. Doctor Rodger's term will expire in October, 1973. Other physicians serving with him are Roger DeBusk, M.D., Detroit; Andrew D. Hunt, Jr., M.D., East Lansing, and Byron P. Brown, M.D., Charlotte.

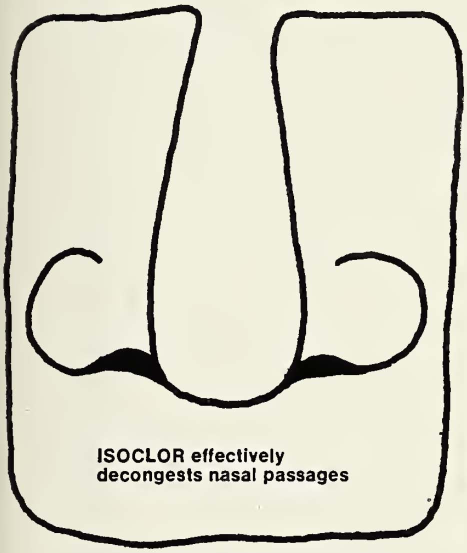
Doctor Post Elected President Of West Michigan Academy

J. Jay Post, M.D., Allendale, is the new president of the West Michigan Academy of General Practice.

William Flintoff, M.D., Grand Rapids, is the new president-elect. Robert Westerhoff, M.D., Grand Rapids, is the vice-president, and G. E. Braunschneider, M.D., Grand Rapids, is secretary-treasurer.

Doctor Post is a past president of the Ottawa County Medical Society.

HERE ARE THE COLD FACTS:



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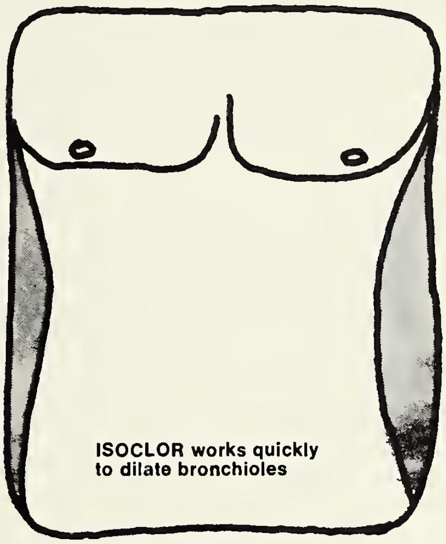
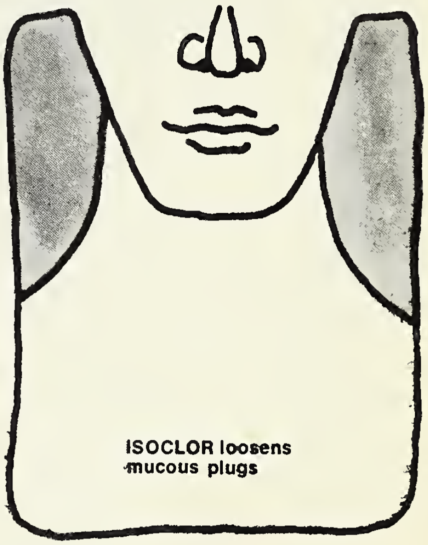
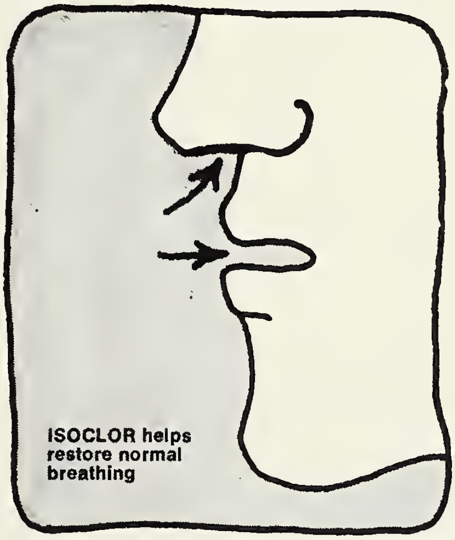


ISOCLOR works quickly to dilate bronchioles



ISOCLOR loosens mucous plugs

ISOCLOR relieves runny eyes



ISOCLOR helps restore normal breathing

ISOCLOR promptly and effectively combats symptomatic miseries of the common cold and influenza

ISOCLOR helps patients face the cold facts

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DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

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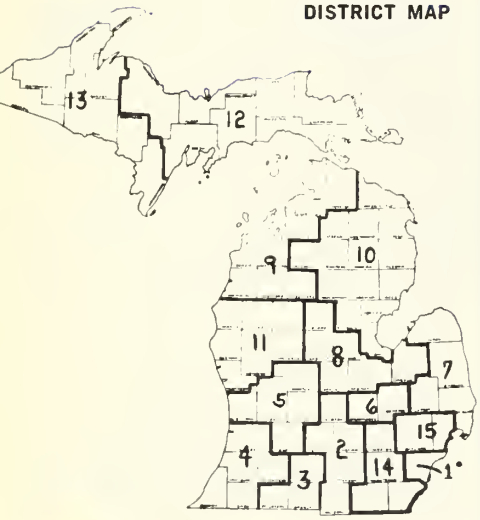

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Crisis Time

A great philosopher wrote: "Is it in destroying and pulling down that skill is displayed? — The shallowest understanding, the rudest hand, is more than equal to that task."

Destructive criticism inevitably increases during crises. Just when understanding and sincere support is needed most, the barren kind of criticism, saying what a thing is not, comes winging in.

What is not needed at this time is carping criticisms. What is needed is constructive comment.

Today, the medical profession is in a crisis which is going to continue at least until July. The crisis is part of the total picture of the Medicare-Medicaid situation. The Senate Finance Committee has issued a report, and hearings will be held. We will read in the press the bleatings of the blasphemers who, to advance their own selfish purposes, will malign our profession.

What should we do? We cannot answer each attack and expect to win the publicity battle. We cannot be completely innocent of every criticism made. We cannot even make every change suggested by either our enemies or our friends.

But we can do this. We can maintain our cool and our unity. We can expect our leaders to discuss and after careful review, to act.

This is particularly apropos of the relationship of MSMS with Michigan Blue Shield. The great majority of criticism of Michigan Blue Shield arises from its position as administrator of Medicare-Medicaid. Some of the criticism relates to basic principles but a great part of it comes from things Blue Shield has done that are just plain irritating to some doctors. The reasoning is that we might accept such irritants from government but not from our own. We forget that *insofar as Medicare-Medicaid is concerned,* Michigan Blue Shield is quasi-governmental. It is attempting to walk a tightrope between the basically dictatorial wishes of government, the basic freedom-from-regulations that the profession would prefer, and what is *must* do as the sole *payor* of Medicaid monies.

The MSMS wants to hear the opinions and experiences of its members. We want to hear from the silent majority — patients who have received our doctors' services under Medicare and Medicaid. We will — and have, via our House of Delegates — taken action to try to improve things generally: We have Peer Review committees to remove any misunderstanding specifically.

But this is the time when irresponsible boat rocking can upset the monumental progress that has been made by the great doctors who have preceded us. Twenty years ago the doomsayers said, "Forget the fight. We have lost and we are going to have socialized medicine." Yet, an entire generation of doctors has passed, and we still have many of our professional freedoms intact (at least as many as other segments of the population!). Hasn't part of this been due to the services of the Blue Shield Plan?

Robt. J. Mason, M.D.
MSMS President

Let us be watchful, alert, and act with all due speed when there is at least a 50-50 chance of *improving* things. What is needed are ideas for improvement based on personal observations — not hearsay evidence or rumored allegations.

your opinion please

There has been considerable debate whether medical care for every individual is a right or a privilege. What are your views?

An item of relevance to this month's question is the statement of policy adopted by the AMA House of Delegates at its 23rd Clinical Convention in Denver Nov. 30-Dec. 3. It is as follows: "It is a basic right of every citizen to have available to him adequate health care; it is a basic right of every citizen to have a free choice of physician and institution . . . ; the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person."

Joel I. Hamburger, M.D.
Southfield

Although this question might have been worth discussing in 1950, or possibly even in 1960, in 1970 the question is clearly irrelevant. Instead of wasting time debating or decrying the obvious, physicians would be better off suggesting methods to implement a program providing quality care for everyone, without regard to economic limitations, which still preserves the right of the physician to practice medicine without bungling bureaucratic interference.

We physicians must accept part of the responsibility for failures of Medicare and Medicaid. Instead of accepting the reins of leadership, we have continually immersed ourselves in discussions which are a generation behind the times. As a result, the social planners have stepped in to fill the vacuum, and we are left holding the bag when the plans predictably fail.

Can we not see far enough in the future to recognize what has to be done and take the leadership in designing a plan for a national health service?

Malcolm K. Dolbee, M.D.
Standish

"Right — A just and fair claim to anything whatsoever —"

"Privilege — An advantage enjoyed by a person beyond the common advantages of other individuals —"

With the above definitions in mind, the question of whether medical care is a right, or a privilege, is non-debatable. Every human being has the right to good medical care simply by virtue of being a member of the human race. The only debatable point in the question proposed is who has the responsibility of delivering this care, how shall it be delivered, and how shall it be paid for?

The recent public outrage concerning the treatment of Biafran children emphasizes the civilized world's opinion that medical care is a right, not a privilege.

It is my personal opinion that this right belongs to the unborn child, and must be considered when discussing abortion. It extends through the neo-natal and early childhood periods, when proper food becomes a necessary part of good medical care, and it encompasses the growing adolescent when venereal disease, drugs, and smoking become the chief threat of good medical care. It extends throughout the adult working years, whether employment be in our type of society, or whether it be in the more primitive societies such as Biafra. There can be no argument that good medical care is a right of the elderly who no longer can afford to pay for this once-given "right" from their own pocket.

The responsibility of delivering this right is another matter. I do not believe that it is the responsibility of those in medicine to furnish free medical care to all who request it, anymore than the plumber should furnish free plumbing to all who request it, or the builders furnish housing free to all who need it. The doctor, who is practicing medicine, should actually be no more required to give away his talents than the attorney should give away his talents, or the grocer his groceries.

We come back, then, to the eventual concept that only the government can guarantee the fulfillment of the right of medical care, and the reimbursement of those who are delivering this care.

It is equally important, that during this interchange, the right of the physician to maintain his own goals in life, his own conditions of work, and his own salary be maintained.

The A.M.A. for years has opposed governmental subsidies of families who need help in obtaining the right to good medical care, but I am not at all certain that this is the opinion of most physicians who are actually practicing medicine. Sometimes, I think the A.M.A. policy speaks for very few. I think very few of us today would abandon the system of Medicare and Medicaid, burdensome though it may be. I have seen it bring help to many who would be begging for this same help under previous conditions.

Good medical care must never be allowed to become a "privilege — an advantage enjoyed by a person beyond the common advantages of other individuals," whether we speak of American whites, blacks, Africans, Biafrans, or any other member of the human race, who simply by becoming a member of the human race has inherited the right to good medical care.

Raymond J. Barrett, M.D.
Detroit

The great liberating documents of history, the Magna Carta and the English, French and U.S. Bills of Rights have proclaimed the natural *rights* of man—in essence Life, Liberty and the Pursuit of Happiness. None mention purchasable commodities such as food, clothing, housing, education or medical care. One was presumed able to pursue these goals by his own efforts and exertion. Denial of one's *right* to work would therefore be unjust.

I feel that much of the chaos of our time may be laid upon the shoulders of a vocal coterie of planners and Self Proclaimed Intellectuals (hereinafter referred to as S.P.I.) who have taken it upon themselves to redefine man's rights. Thus, under the interpretation of the S.P.I., the natural right to Life is currently being attacked via abortion reform.

Let us review a decade of Liberty as interpreted by the S.P.I. Revel in the *rights* of criminals which have been so interpreted and expanded that the cities have become dying jungles. Glory in the enlightened progress whereby we have lost the *right* to pray in public schools, but instead have been given the *right* to circulate pornography to children. Exult in the newly-discovered *right* to disrupt religious services and to shut down and partially destroy public educational institutions in which the great majority of students desire only to pursue an education. Admire the wisdom of the S.P.I. who would simultaneously advocate abolition of the *right* to smoke cigarettes but replace it with the *right* to smoke marijuana.

Now let us proceed to the Pursuit of Happiness as interpreted by the S.P.I. Adequate food, clothing, housing and medical care are certainly desirable.

However, a small minority of the population (don't trust the S.P.I.'s estimate), by reasons of poverty, misfortune, retardation or disinclination is not able to obtain reasonable quantities of these commodities and services by its own efforts. While an enlightened society will take care of its less fortunate brethren, this does not satisfy the S.P.I. He perceives the embarrassment of one who receives aid and must periodically prove the necessity for its continuance. He proceeds to make this the major issue and solves it by creating a Never Never Land Of Make Believe. He pronounces that aid is not aid but a *right,* and therefore as a *right* must be provided for all the population by the government. With the dual cynicism of conviction that others do not know what is best for them, but that he does, and must therefore impose his will, he attempts to overrule all opposition. Proposed alternatives are denounced as reactionary.

Once having accepted the spurious premise of the S.P.I. on the right to medical care, one cannot thereafter logically deny the equally necessary *right* to food, clothing and housing — to avoid embarrassment to the small segment who received these commodities as aid, the government must then supply them as a *right* to all citizens. Carried to its logical conclusion, we are in 1984 — the world of George Orwell and Big Brother Knows Best. The S.P.I., of course, denies this, and heaps disdain on those who would oppose his program.

How to Make Medical Education More Relevant?

"Your Opinion Please" is a monthly feature in *Michigan Medicine* designed to provide a forum for the views of Michigan physicians on vital issues. Your comments are invited in response to the question asked on this page.

A question is selected each month and interested physicians are urged to send in their reactions. Letters in response to the question for the June issue must be received in the MSMS office by May 1.

The June question, for which responses have been solicited from student leaders in Michigan's medical schools, will be:

"What suggestions would you offer to make medical education today more relevant to health care needs?"

North Central Physicians Support Parents Classes

Classes for expectant mothers were supported at North Central Michigan College by members of the Northern Michigan Medical Society during February and March. The classes were presented by the District Health Department, in cooperation with Lockwood-MacDonald Hospital and Women's Auxiliary, Little Traverse Hospital and Women's Auxiliary and North Central Michigan College.

Ottawa Physicians Discuss Drug Abuse

Drug Abuse was the topic of the Ottawa County Medical Society's February meeting. Guest speaker was Walter D. Meester, M.D., director of research at Blodgett Memorial Hospital in Grand Rapids. He discussed diagnosis, treatment, rehabilitation and educational programs.

Ingham Physicians Urged to Get Involved

"Physicians must become more involved in political, economic, educational and social decisions and actions," Justin L. Sleight, M.D., Lansing, has told the members of the Ingham County Medical Society. One of the most recent community-type projects in Ingham was a county medical society survey of physician manpower.

Alcohol Withdrawal Discussed by Macomb Society

A talk on Medical Management of Acute Alcohol Withdrawal highlighted the program at the February meeting of the Macomb County Medical Society. The physicians heard Russell Smith, M.D., medical director of the W. J. Maxie Boys Training Hospital, Brighton.

Baseball Stars Highlight Oakland Father-Son Meeting

The annual Father and Son Evening, featuring Vince Desmond, director of special events, and Jim Price, catcher, of the Detroit Tigers, was enjoyed in February by members of the Oakland County Medical Association.

Ottawa Society Active With Annual Career Exhibit

The annual Career Worlds exposition, with a major portion of the exhibits devoted to medical careers, is scheduled from April 22-24 this year at the Civic Center, Holland. Expanded to three days over last year's two-day exhibition, the Career Worlds is the outgrowth of a one-day medical careers day started in 1967 by the Ottawa County Medical Society. The Ottawa Society continues to be a major sponsor of the Career Worlds show.

Dr. Cooper, Dr. Cook—Which County Society Leader Do You Mean?

If you were to drive around to confer with the presidents of county medical societies, you'd stop in Kalamazoo to see President Paul F. Cooper, M.D., of the Kalamazoo Academy of Medicine, and then head west on M-43 toward Van Buren County where you'd call on another Doctor Cooper! This year, Joseph E. Cooper, M.D., of Bangor, is the Van Buren County Medical Society president.

This coincidence might happen once, you say, but not twice? Wrong. The president of the Bay-Arenac-Iosco Medical Society is Hugh K. Cook, M.D., Bay City, and straight north up US-23 in the adjacent medical society is another President Cook. Thomas J. Cook, M.D., Alpena, is president of the Alpena-Alcona-Presque Isle Medical Society. Any meeting we might have of county medical society leaders also would include Bruno C. Cook, M.D., Westphalia, who is secretary of the Clinton County Medical Society.

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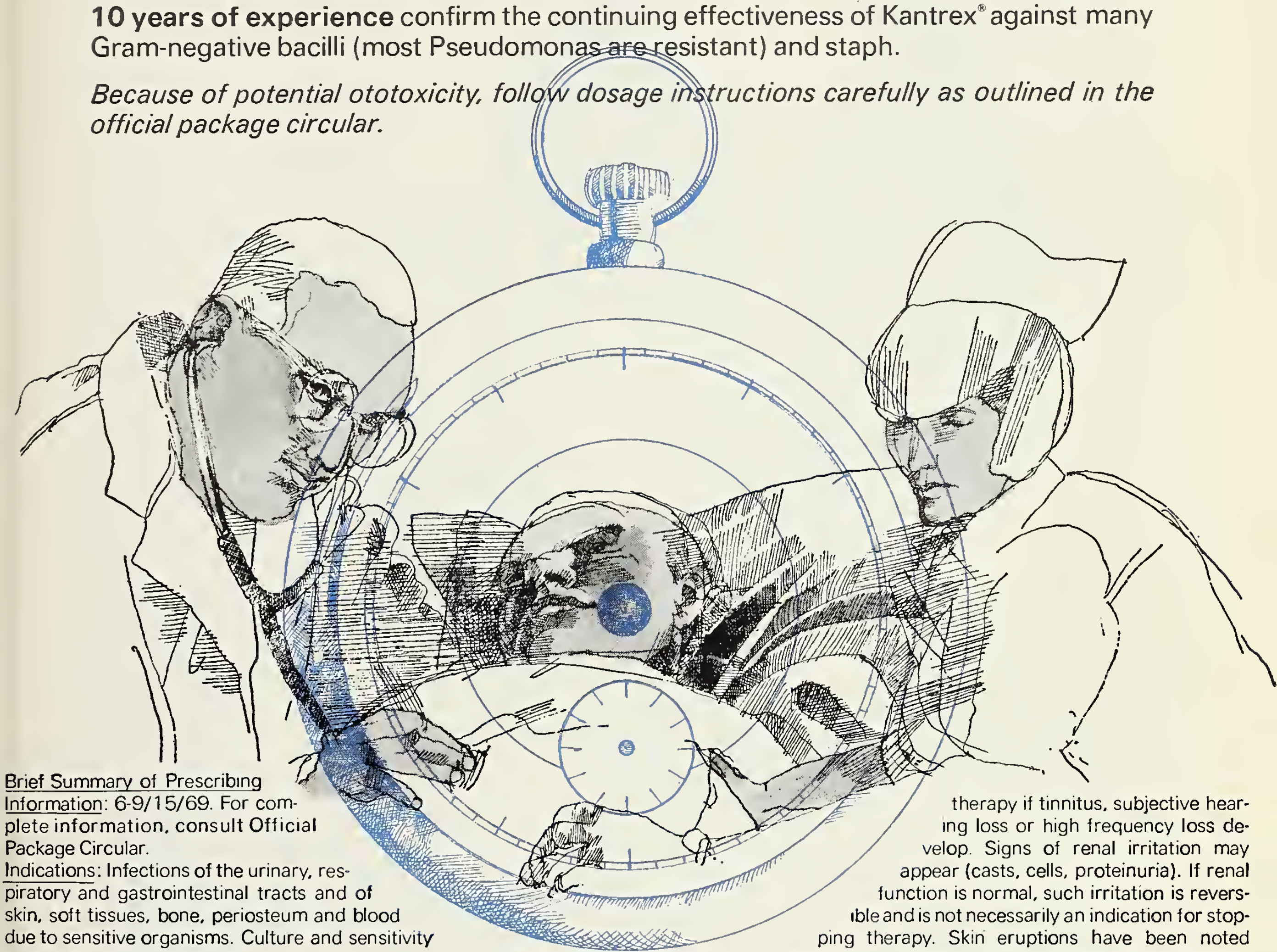

Brief Summary of Prescribing Information: 6-9/15/69. For complete information, consult Official Package Circular.
Indications: Infections of the urinary, respiratory and gastrointestinal tracts and of skin, soft tissues, bone, periosteum and blood due to sensitive organisms. Culture and sensitivity studies should be performed.
Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.
Warnings: Since the drug is excreted almost entirely by glomerular filtration, renal malfunction can cause abnormally high serum levels of kanamycin which may prove ototoxic. Assess renal function periodically, both before and during therapy. Renal dysfunction or pre-renal azotemia sharply increase the risk of ototoxicity and permanent deafness. In such cases decrease the size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. In older patients and patients receiving a total dose in excess of 15 Grams, watch carefully for signs of ototoxicity.
Precautions: If mycotic or bacterial superinfection occurs, discontinue kanamycin and initiate appropriate therapy. Cumulative ototoxic effects may be produced by concurrent or consecutive use of other ototoxic drugs. High doses may cause irritation at injection sites. The drug *should not* be physically mixed with other antimicrobials.
Adverse Reactions: Severe irreversible hearing loss may occur. Stop therapy if tinnitus, subjective hearing loss or high frequency loss develop. Signs of renal irritation may appear (casts, cells, proteinuria). If renal function is normal, such irritation is reversible and is not necessarily an indication for stopping therapy. Skin eruptions have been noted rarely. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in postoperative patients until recovery from anesthesia and muscle relaxants is complete.
Dosage and Administration: The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gram daily and should not exceed 1.5 Gram even in the heaviest patients. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours.
Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. 1.0 Gm. in 3 ml.
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A REPORT OF SUCCESSFUL MANAGEMENT BY SPLENECTOMY

Solitary Splenic Abscess

BY DONALD H. KUIPER, M.D.
EAST LANSING
JOHN P. PAPP, M.D.
NORMAN W. THOMPSON, M.D.
BOTH OF ANN ARBOR

INTRODUCTION

Splenic abscess has become an unusual clinical occurrence. In the pre-antibiotic era the incidence of splenic abscess was 0.4% in 7,914 autopsies at the Boston City Hospital.[1] Since the introduction of antibiotics, the occurrence has become so rare that it is usually not considered in the differential diagnosis of left upper quadrant pain or fever of unknown etiology.

We recently cared for a patient with a large solitary splenic abscess. An additional case was found when our experience at the University of Michigan Medical Center over the past 33 years was reviewed. The purpose of this communication is to relate the course and successful management of our patient by splenectomy.

CASE REPORT

UMMC #1127180 J.S., a 24-year-old white woman was admitted to the University of Michigan Hospital on October 4, 1968, for the evaluation of progressive bilateral pulmonary infiltrates. She had been in excellent health until the afternoon of September 22, 1968, when she fell on a sidewalk, striking her left leg and thigh without breaking the skin. Eight hours later she awoke with pleuritic left chest pain. On admission to another hospital on September 23, a left basilar infiltrate was seen on chest X-ray. Initially her temperature was 99.6°F. and her WBC was 20,500. Sputum cultures grew Klebsiella, staphylococcus aureus, and Beta hemolytic streptococci. Despite treatment with several antibiotics, she developed bilateral pulmonary infiltrates and had a daily spiking fever to 104°F. She was transferred to the University Hospital 10 days after this onset of her illness.

ON ADMISSION she appeared tachypneic and complained of left shoulder pain. Examination of the chest revealed the left hemidiaphragm to be higher than the right. Both hemidiaphragms moved about 3 cm with inspiration. Breath sounds were decreased at the left posterior base. There was no clinical evidence of thrombophlebitis in the lower extremities.

Hemoglobin was 9.9 g% and the WBC was 18,000/mm³ with a left shift. The serum alkaline phosphatase on two occasions was 30 KA units. Serum bilirubin was 0.5mg%, SGOT was 68 units and pyruvic transaminase was 40 units, serum LDH was 126 units with elevated isoenzyme fractions II, III, and V. The serum leucineamino peptidase was 360 units (Normal 80-170) and the 5' nucleotidase 18 units (Normal 0-7 I.U.). Protein electrophoresis showed a total of 7.0 g% with a slight elevation of the alpha-2 and beta fractions. Sputum cultures revealed a few colonies of coagulase negative staphylococci. Multiple blood cultures produced no growth. No viral agents were isolated from stool, sputum, nose, or throat swabs. The urinalysis, BUN, creatinine, serum electrolytes, calcium, phosphorous, amylase, lipase, cold and febrile agglutinins, compliment fixation for fungi and VDRL were all normal. Antinuclear factor on two occasions were negative. Histoplasmin and old tuberculin skin tests were negative. Chest X-ray showed bilateral basilar infiltrates compatible with pneumonia or a pulmonary infarction (**Fig. 1**).

Two grams of Erythromycin was given daily for the first 5 days of hospitalization. Intravenous heparin was given. Despite persistent daily spiking fever of 101-102°F., gradual subsidence of the

scientific papers

Dr. Kuiper is an Assistant Professor of Medicine at Michigan State University. Dr. Papp and Dr. Thompson are with the Department of Internal Medicine and Section of General Surgery, University of Michigan Medical Center. Their report was supported in part by the American Cancer Society.

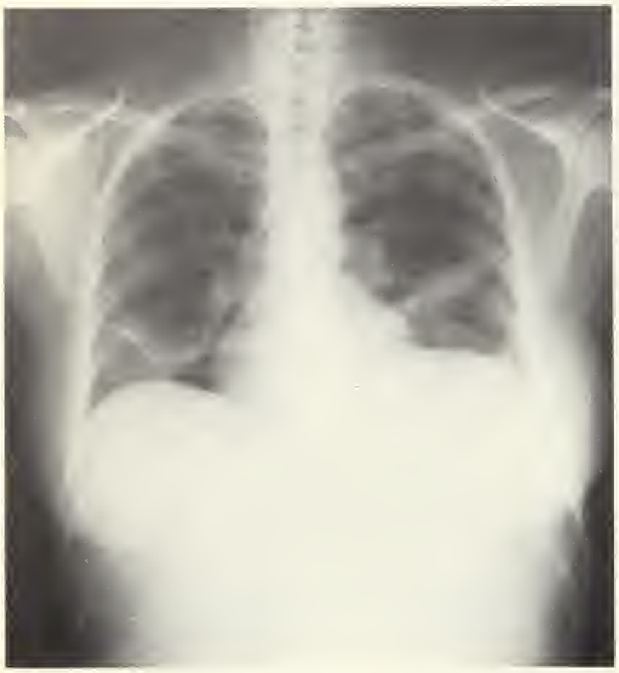

Fig. 1 Admission Chest X-ray showing bilateral lower lobe infiltrates compatible with pneumonia or pulmonary infarction.

pleuritic left chest pain occurred. On October 10, she complained of vague left upper quadrant pain which progressed in severity. An intravenous pyelogram on October 11 showed left renal displacement caudally, by a large left upper quadrant mass (**Fig. 2**). Two areas of calcification were seen within the confines of the mass. A selective splenic arteriogram showed an intrasplenic mass, 12 x 20 cm in diameter. Puddling of the contrast media near the splenic hilus was interpreted as evidence of active bleeding into the mass.

POSSIBLE DIAGNOSES that were entertained prior to arteriography were: Delayed splenic rupture, pancreatic pseudocyst and lymphoma. Following arteriography, the patient was taken to the operating room with a diagnosis of delayed splenic rupture with possible secondary infection of the hematoma. At celiotomy, a football sized abscess involving most of the spleen was found. The abscess was decompressed and splenectomy was performed. Careful evaluation of other abdominal viscera revealed no source of infection or other abscesses.

The spleen weighed 670 grams and measured 14 x 16 x 10 cm. (**Fig. 3**). It was estimated that abscess cavity contained about 500 ml of yellow-brown purulent material. Microscopic examination

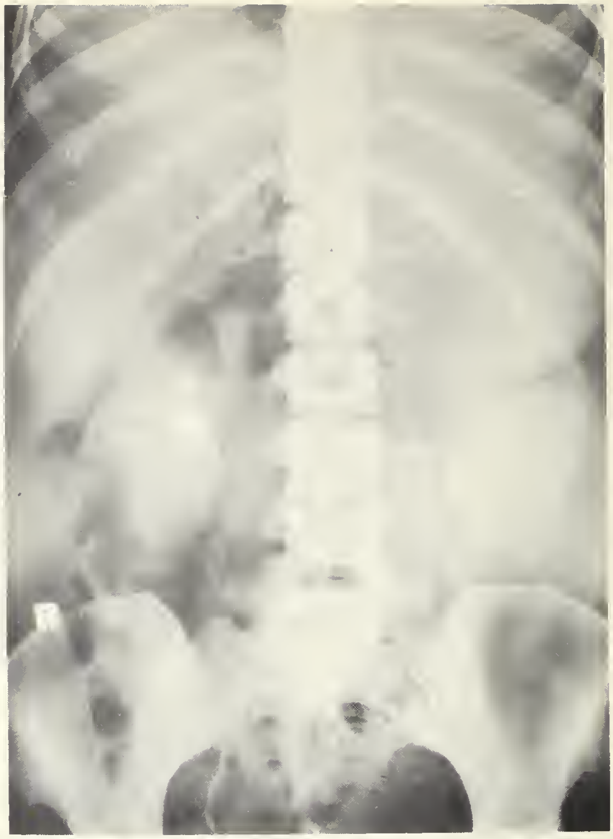

Fig. 2 Intravenous pyelogram showing displacement of the left kidney injury by a large upper quadrant mass.

of the cavity wall was interpreted as a chronic pyogenic abscess. Cultures grew out coagulase positive staphylococci.

The patient's postoperative course was complicated by left lower lobe pneumonia and thrombophlebitis. After treatment with Lincomycin, she became afebrile. Since her discharge on November 2, 1968, she has remained in good health.

DISCUSSION

Secondary splenic abscesses arise as sequela to infections elsewhere in the body. McSherry and Dineen[2] reported that 75% of splenic abscesses are "metastatic." Many primary sources have been reported and include lung abscess, pneumonia, endocarditis, dental infections, otitis, dermatitis, peritonsillar abscess, appendicitis and thrombophlebitis.[3] Another 15% of splenic abscesses follow splenic trauma[4] and 10% are due to contiguous spread from an adjacent infected organ such as a perforated colonic diverticula or neoplasm.[2] In the latter two categories, the physician's index of suspicion is already raised because of the primary disorder.

It is in the patient with a splenic abscess secondary to a primary infection elsewhere, that the diagnosis is easily overlooked. The clinical manifestations of splenic abscess may develop within a day or several months after the onset of the primary infection or the traumatic episode.[5, 6] With a long latent period the primary focus or traumatic episode may be forgotten.[7]

IT SEEMS that our patient most likely developed phlebothrombosis, complicated by pulmonary emboli, secondary to her fall. Subsequent superimposed bacterial infection resulted in bacteremia with splenic seeding. Her complaints of left lower chest and shoulder pain were initially ascribed to parietal pleural and diaphragmatic inflammation, respectively. As her chest pain resolved, symptoms of what subsequently proved to be a large splenic abscess were manifest.

Multiple microscopic splenic abscesses are not an unusual finding in septicemia. However, we could not recall having seen a large isolated splenic abscess. Records of the University of Michigan Hospital were reviewed between 1936 and 1968. Only one previous patient was found to have a splenic abscess cavity of similar magnitude and it was secondary to a perforated gastric ulcer. Cultures grew out Clostridium perfringens.

PATIENTS WITH splenic abscesses may have left upper quadrant pain, fever, splenomegaly, left pleural effusion, left lower lobe atlectasis, left shoulder pain or a left upper quadrant friction rub. These signs and symptoms have even greater significance if there is a recent history of sepsis. The diagnosis of splenic abscess must be suspected in any patient with a history of sepsis or left upper quadrant trauma who fails to respond to reasonable antibiotic therapy.

In addition to the historical and physical clues, radiographic features may appear in the patient with splenic abscess.[8] Chest X-ray may show a left pleural effusion, an elevated left hemidiaphragm and a medial displacement of the gastric bubble. A left upper quadrant soft issue mass with or without an air-fluid level representing liquefaction necrosis within the splenic abscess may be seen in an abdominal scout film. Barium enema may show an inferiorally displaced splenic flexure. An intravenous pyelogram may reveal a downward displacement of the left kidney. Although none of these roentgenographic features are pathognomonic for splenic abscess, their presence in the proper clinical setting may lead one to make the correct diagnosis. Selective arteriograms may show an intra-splenic mass suggesting cyst, hematoma tumor or abscess. As in this case, an exact diagnosis could not be established on the basis of arteriograms alone.

THE OVERWHELMING majority of patients succumb to infections if surgical intervention is not undertaken.[5, 9] In the pre-antibiotic era the mortality ranged from 80-100%.[6] Splenectomy is the treatment of choice accompanied by prompt culture and antibiotic sensitivity of the organism for appropriate systemic antimicrobial therapy.

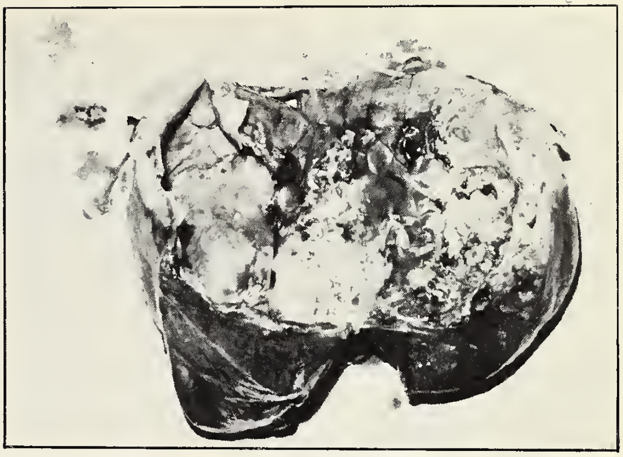

Fig. 3 Bisected spleen with abscess cavity evacuated.

SUMMARY

A patient with a solitary splenic abscess successfully managed by splenectomy and antibiotic therapy, is reported. Review of our experience over the past 33 years revealed only one other case. Predisposing factors, physical and radiographic signs of splenic abscesses are reviewed.

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Monthly Surveillance Report

Cases of Certain Diseases Reported To the Michigan Department of Public Health For the Four-Week Period Ending February 27, 1970

	1970 THIS 4-WEEK PERIOD	1969 SAME 4-WEEK PERIOD	1970 TOTAL SAME DATE	1969 TOTAL SAME DATE	TOTAL CASES FOR 1969
Rubella	299	302	616	468	4307
Measles	84	38	124	50	401
Whooping Cough	17	15	24	19	192
Diphtheria	—	—	—	—	—
Mumps	637	612	1139	978	5215
Scarlet Fever & Strep Sore Throat	1503	1080	2713	1998	9763
Tetanus	1	1	1	1	6
Poliomyelitis (Paralytic)	—	—	—	—	—
Hepatitis	325	270	748	483	3360
Salmonellosis (Other than S. Typhi)	40	30	91	67	539
Typhoid Fever (S. Typhi)	—	—	1	—	6
Shigellosis	11	29	28	63	300
Aseptic Meningitis	6	11	11	18	179
Encephalitis	4	3	12	13	120
Meningococcic Meningitis	5	3	15	25	114
H. Influenza Meningitis	4	5	12	7	56
Tuberculosis	167	189	392	395	2108
Syphilis	276	371	600	808	4021
Gonorrhea	1529	1328	3567	2937	19,194

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Acting Director
Michigan Department of Public Health

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Michigan Authors

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WITH FETAL CHROMOSOMAL ENDOREDUPLICATION

Granulocytic Leukemia In Pregnancy

BY J. KADOWAKI, M.D.
K. S. MOGHISSI, M.D., F.A.C.O.G.
G. N. LOOMUS, M.D.
ALL OF DETROIT

Pregnancy complicated by chronic myelogenous leukemia is uncommon. Busulfan (Myeleran) appears to be the chemotherapeutic agent of choice for the treatment of this hemotological disorder. However, some reservation has been expressed as to whether the administration of busulfan will not have a harmful effect upon the baby. Several case reports have appeared in the literature in which the mother has been treated with this drug during pregnancy and delivered normally without apparent untoward effect to the newborn infant.[1]

This report concerns the operative delivery of an apparently normal infant following busulfan therapy during pregnancy with transient cytological evidence of endoreduplication.

CASE REPORT

A 20-year-old Negro, gravida 4, para 2 noted weakness and weight loss at the onset of her last pregnancy. She was first seen in the prenatal clinic three months before the expected date of confinement when she complained of bleeding gums, night sweats, fever and dizzy spells. She was admitted to the University Service at Hutzel Hospital in Detroit.

Her first pregnancy resulted in delivery of a 5 lb. 2 oz. normal male infant at 7 months gestation. The second pregnancy was terminated by Cesarean section with delivery of a 7 lb. 10 oz. male infant. Multiple blood transfusions were given following the second delivery because of hemorrhage. The third pregnancy ended after three months with uterine curettage for incomplete abortion. Another transfusion was given.

Physical examination revealed a well-developed female with normal vital signs. The conjunctivae were pale and gums hypertrophied. The spleen was palpable 10 cm. below the costal margin, and the uterus was compatible with a 28-week pregnancy. Fetal heart tones were normal.

Hematological studies revealed anemia and a blood picture compatible with chronic myelogenous leukemia. This diagnosis was confirmed by bone marrow examination. The bone marrow alkaline phosphate score was 4. Coagulation studies, including thromboplastin generation tests, were normal except for a slightly prolonged prothrombin time. Multiple blood transfusions were given and busulfan therapy begun (Fig. 1).

At 39 weeks of gestation, a Cesarean section was performed with bilateral tubal ligations and biopsies of the right ovary and the uterus. Hydrocortisone was administered intravenously during operation along with 500 ml. of fresh blood. There was fibrinoid degeneration and fibrosis of the placenta. The myometrial and ovarian biopsies were normal. The umbilical cord was yellow with softening and degeneration of Wharton's jelly. Postoperatively, paralytic ileus occurred with a generalized oozing of blood from the uterus and the abdominal incision. Chest X-ray suggested pulmonary embolism in the left lower lobe. Following transfusion with 2,500 ml. of whole blood, the patient recovered and busulfan therapy was continued for 8 weeks postpartum. The patient remained in a clinical and hemotological remission for a year after the delivery.

The 6 lb. 6 oz. infant appeared normal at birth. The examination of the cord blood did not show any abnormality except for an elevated platelet count of 1,255,000 per Cu. mm. His subsequent course was complicated only by the development

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The authors are with the Departments of Gynecology and Obstetrics, Pediatrics and Medicine at Wayne State University School of Medicine and are also affiliated with Hutzel Hospital and the Child Research Center of Michigan in Detroit. Their study was supported in part by a grant from the Children's Leukemia Foundation of Michigan.

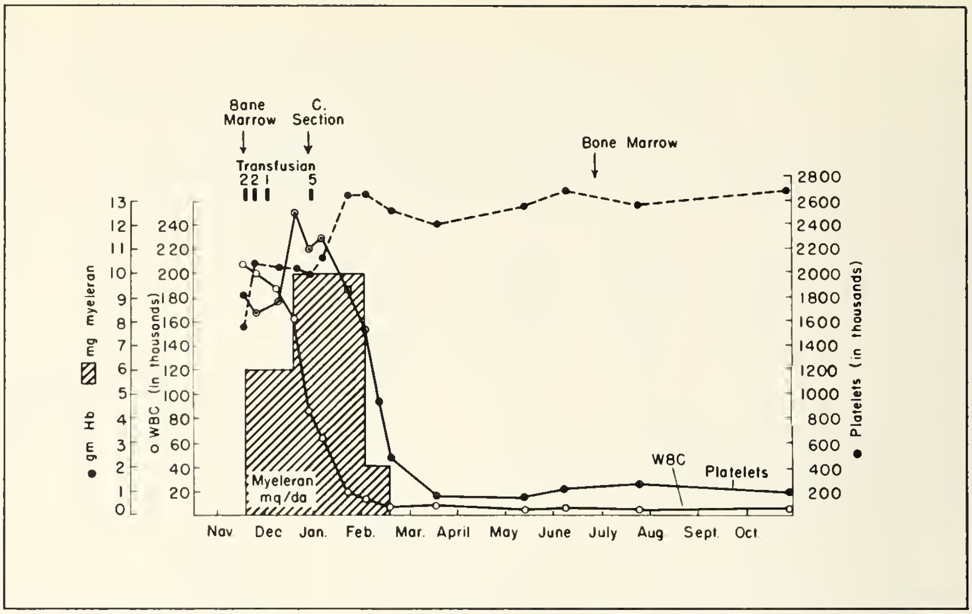

Figure 1. Peripheral blood picture and management of the patient in the first year following the diagnosis.

WBC = White blood cells Hb = Hemoglobin

of a moderate hyperchromic (iron deficiency) anemia at 7 months.

Cytogenetic studies of the maternal bone marrow disclosed a model number of 46, with 95% of the cells bearing a Philadelphia chromosome but no endoreduplication. Philadelphia-chromosome-bearing cells were, also, seen in a number of cells cultured with phytohemagglutinin by the method of Moorehead *et al.*[2]

The infant's cord blood showed no Philadelphia chromosomes. Four cells with endoreduplication of the chromosomes were found in 244 mitotic cells examined, an incidence of 1.6 per cent. No xx cells were seen (Fig. 2). Subsequent blood specimens obtained at 3, 5, and 8 months showed normal karotypes with no endoreduplication.

DISCUSSION

Endoreduplication has been reported to occur in association with treated or untreated leukemia,[3,4] congenital abnormalities[5] and following chemotherapeutic agents and radiation therapy.[6,7] Its incidence in healthy males and females has been variously reported to be 0.23[8] and 0.3[9] per cent of the cells examined. The 1.6 per cent of endoreduplicated cells present in this case is therefore significantly higher than that observed in normal population. The rapid processing of the cells and rare occurrence of endoreduplication in our routine procedure prompt us to believe that a phenomenon such as that observed by Boczkowski[5] during processing of cells is not likely to be responsible for this chromosomal aberration.

Transplacental passage of leukemic cells from the maternal to the fetal circulation has been reported.[10] Since there was no evidence of abnormal cells bearing Ph1 positive chromosomes or normal cells of xx constitution in the cord blood, the occurrence of endoreduplication in normal lymphocytes of the infant must be attributed to other factors. These may include the transplacental passage of busulfan and a particular sensitivity of fetal lymphocytes to this compound.

Absence of endoreduplication in the mother may have been due to a lesser sensitivity of the maternal lymphocytes to the drug.

SUMMARY

A case of chronic granulocytic leukemia associated with pregnancy is presented. The mother was treated with busulfan and delivered successfully by Cesarean section of a normal infant. Cytogenetic study of the cord blood revealed transient chromosomal endoreduplication possibly related to maternal ingestion of busulfan.

ACKNOWLEDGEMENTS

We wish to express our thanks to Mrs. R. I. Thompson for her technical assistance and to Dr. W. Zeulzer for his help in preparing the manuscript.

REPRINTS

Requests for reprints should be addressed to Kamran S. Moghissi, M.D., Wayne State University School of Medicine, 550 E. Canfield, Room 113, Detroit, Mich. 48201.

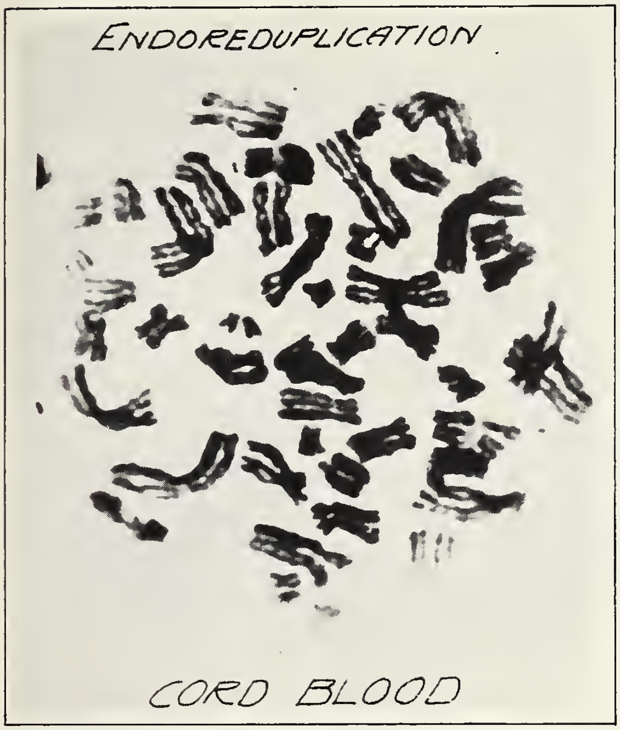

Figure 2. Karyotype of infant's cord blood showing endoreduplication (doubling) of the chromosomes.

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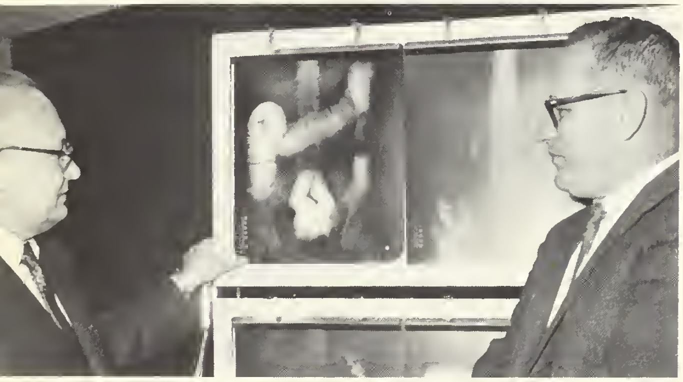
MSMS Spring PG Clinics Begin April 9

A QUINTETTE of interested physicians examines a young patient with cataracts at the Midland PG Conference.



IN ALPENA, Wayne State University Professor of Medicine V. K. Vaitkevicius, M.D., left, led the fall PG course. Above, he discusses X-ray exhibit with Henry Stibitz, M.D., Alpena, president of the Tri-County Medical Society (Alpena, Presque Isle and Alcona Counties).

VISITING PHYSICIAN Harry A. Towsley, M.D., Ann Arbor, center, director of Postgraduate Medical Education Programs at the University of Michigan Medical Center and chairman of the MSMS Postgraduate Medical Education Committee, was a guest consulting physician at the fall Midland clinic. He welcomes William A. Maynard, M.D., Coleman, left, and Kuno Hammerberg, M.D., Clare.

Twice a year, MSMS sponsors a series of postgraduate clinics for physicians around the state, attended by consulting physicians from Michigan's medical schools, who provide an expert's observations.

This spring, the PG series is scheduled to begin April 9, with the first two clinics in Alpena and Grand Haven.

The series of pictures on this page were taken during fall PG clinics in Alpena and Midland, and reflect the variety of activities which take place at a "wet clinic." Most of the PG clinics take place in the afternoon, followed by dinner and a talk by one of the visiting physicians.

Cardiovascular Roentgenology: Conventional Studies

BY M. VIAMONTE, JR., M.D.
MIAMI BEACH, FLA.

Cardiac fluoroscopy and chest roentgenography complement history, physical examination and electrocardiography for the optimal evaluation of patients who have known or suspected cardiovascular disease.

Fluoroscopy is best accomplished using an image intensifier with optical or television monitoring. The major contribution of cardiac fluoroscopy is for the identification of abnormal calcifications for the detection of abnormal cardiac contractility and for the analysis of chamber enlargement. Cardiac fluoroscopy also aids in the recognition of pericardial effusion and the analysis of cardiac contractility and great vessel pulsation. Diaphragmatic mobility and changes in size of pulmonary nodules or masses when performing the Valsalva and Muller maneuvers may be observed via fluoroscopy.

Cardiac fluoroscopy especially in infants, children and women in the child bearing age should be conducted using minimum exposure and maximum patient protection. It is our policy to analyze the chest roentgenograms prior to the fluoroscopic examination. A barium swallow study should be done as part of the fluoroscopic examination. Routine chest roentgenograms for cardiovascular evaluation at our institution include the following 5 films: 1. Postero-anterior chest roentgenogram without barium; 2. Left anterio-oblique view at 45° without barium; 3. Right anterio-oblique view at 60° with barium; 4. Left lateral view with barium, and 5. Postero-anterior view, overpenetrated with barium. Because the heart is a three dimensional structure all these views are essential for complete evaluation of chamber enlargement.

OVERALL SIZE of the heart is evaluated by the cardiothoracic ratio, which is the maximum transverse diameter of the heart divided by the maximum internal transverse diameter of the chest. This ratio should be less than 50% except in extreme obesity, or when the diaphragm is elevated causing the heart to adopt a horizontal position. Cardiomegaly may be misdiagnosed in the presence of a prominent pleuro-pericardial fat pad. The latter is easily recognized by the relative translucency observed around the apex of the left ventricle at the left cardiodiaphragmatic junction. A pleuro-pericardial fat pad may also exist at the right cardiophrenic angle.

In the postero-anterior view, the right heart border has two arches. The cephalic one is the vascular arch caused by the ascending aorta in adults, by the superior vena cava and right lobe of the thymus in infants and young children, or by the superposition of the ascending aorta and the superior vena cava in certain individuals. The caudal arch of the right heart border is formed by the right atrium.

The upper portion of the left heart border in the frontal projection is formed by the aortic knob (junction of transverse and descending portions of the thoracic aorta). The middle arch is formed by the left border of the pulmonary trunk (upper 2/3), left auricular appendage (lower 1/3), and the proximal portion of the left branch of the pulmonary artery. The caudal arch of the left heart border is formed by the left ventricle.

The left anterior oblique projection separates the left from the right heart chamber. The latter occupy the anterior half of the heart. The posterior heart border is symmetrically convex and appears separated from the left bronchus by a radiolucent area representing aerated lung parenchyma. The anterior half of the heart is occupied by the right atrium superiorly and the right ventricle inferiorly. A line extending the anterior border of the trachea divides the heart in two almost equal halves and usually indicates the plane of the interatrial and interventricular septa. The left anterior oblique projection is utilized during selective angiocardiography for the study of left-to-right shunts at the atrial or ventricular levels. Contrast medium injected into any of the left heart chambers, if seen to be directed anteriorly, indicates the presence of a left-to-right intracardiac shunt. This is also an excellent view for evaluating valvular, subvalvular or supravalvular aortic path-

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The author is with the Department of Radiology at Mt. Sinai Hospital, Miami Beach, Fla. His article is one in a series on clinical cardiology prepared by the American Heart Association and made available to **Michigan Medicine** by the Michigan Heart Association.

ology. The left anterior oblique projection unfolds the thoracic aorta. Left ventricular outflow tract obstructions are best analyzed in this projection. This is the projection of choice for selective injection of the right and left coronary arteries. The right coronary artery is directed anteriorly and the left coronary artery posteriorly. The anterior descending division of the left coronary artery crosses the mass of the heart in the left anterior oblique projection.

The right anterior oblique projection is the view that separates the atria from the ventricles. The right anterior oblique projection should be taken at 60°. The reason for this is that it requires this degree of rotation of the patient in order to separate the heart from the spine. The left and right atrium are projected posteriorly and the right and left ventricle are superimposed anteriorly. This view is most important for selective ventriculography for the evaluation of pathology of the atrioventricular valves. It is also a very important view for the evaluation of atrial enlargement.

The left lateral view of the heart separates the left atrium and left ventricle posteriorly from the right ventricle and right atrium anteriorly. In the lateral projection of the heart, on deep inspiration one usually sees a vertical line crossing the angle formed by the posterior heart border (diaphragmatic portion of the left ventricle) and the left leaf of the diaphragm. This line corresponds to the posterior wall of the inferior vena cava. When the posterior heart border projects dorsal to the caval line this usually is indicative of left ventricular enlargement. The left lateral projection is of importance for the evaluation of heart size in the ventro-dorsal direction, for the evaluation of left atrial, left ventricular and right ventricular enlargement, for the diagnosis of obstructive airway disease (i.e., diffuse obstructive pulmonary emphysema), and for the recognition of thoracic wall deformities, such as sternal depression and the so-called Straight Back Syndrome. This is an excellent view for the analysis of the size of the primary division of the pulmonary artery. The right pulmonary artery usually projects as an oval shadow just caudal and ventral to the tracheal bifurcation. The left pulmonary artery courses above and dorsal to the left bronchus.

The overexposed frontal view of the heart is of value for the recognition of abnormal cardiac calcification, for the detection of an enlarged left atrium, for best localization of the thoracic aorta, and for the analysis of esophagus-heart relationship.

The postero-anterior view of the heart is used for the evaluation of heart size in the frontal plane, and of cardiovascular configurations. The heart is said to have an "aortic or left ventricular configuration" when the left ventricular arch and the aortic knob are prominent. This determines relative narrowing of the waist of the heart (relative concavity of the middle arch of the left heart border). The "mitral configuration" is said to be present when the shadow of the aortic knob is small, the middle arch of the left heart border appears to be straight or convex, and the left ventricular arch is inconspicuous. The left heart border follows a straight line directed from midline to the left hemidiaphragm. A double density caused by left atrial enlargement and inversion of the pulmonary vasculature (upper, medial pulmonary vessels appear larger than lower medial pulmonary vessels) complete the picture of the "mitral cardiovascular syndrome."

The "left-to-right shunt configuration" is said to be present when there is marked convexity of the middle arch of the left heart border and uniform pulmonary vascular plethora. "Fallot configuration" is said to be present when there is prominent rounding of the left ventricular border which appears raised above the diaphragm, the middle arch of the left heart appears concave, and the shadow of the aortic knob is barely visible. This heart configuration is usually associated with pulmonary hypovascularity (secondary to right-to-left shunt). This group of findings is not pathognomonic of Fallot's Tetralogy. It may be seen with other anomalies such as tricuspid atresia and persistent truncus arteriosus.

The so-called "Water Bottle Configuration" is said to be present when the right and left heart borders appear rather symmetric. There is enlargement of the transverse diameter of the heart. The pulmonary vasculature appears to be normal or decreased. This configuration is the consequence of massive pericardial effusion or of cardiac dilatation (primary and secondary myocardiopathies).

OF ALL the heart chambers the left atrium is the easiest to analyze. It is the most posterior chamber of the heart and hence contacts the esophagus. When the left atrium is enlarged, in the frontal projection one may see slight convexity of the lower third of the middle arch of the left heart border due to dilatation of the left auricular appendage. A disc-like density appears in the center of the heart and causes a double density on the right heart border and occasionally accounts for a third arch at the right heart border (the middle one). The interbronchial angle may appear to be widened (greater than 70°) when enlargement of the left atrium is directed superiorly. In extreme left atriomegaly, the esophagus may appear displaced to the right or to the left of the midline. Rarely, one may see atelectasis of the left lower lobe secondary to obstruction of the left lower lobe bronchus from a markedly enlarged left atrium.

In the left anterior oblique projection the enlarged left atrium will obliterate the clear infrabronchial space. One may see elevation of the left main bronchus. In the right anterior oblique projection the esophagus will no longer parallel the thoracic spine. Variable degrees of esophageal displacement may be encountered. Elongated marked esophageal displacement indicates marked left atrial enlargement usually seen with severe degree of mitral insufficiency. Localized, slight esophageal displacement indicates mild left atrial enlargement and predominant mitral stenosis.

Right atrial enlargement is best evaluated in the left anterior oblique projection. Prominence of the superior aspect of the anterior heart border, usually reflects enlargement of the right auricular appendage. In the frontal projection, the right atrial border may appear displaced to the right and cephaled. There may be cephalic displacement of point B (junction of the right atrial border and the vascular arch). The right anterior oblique and left lateral projections are not helpful for the evaluation of right atrial enlargement.

ENLARGEMENT OF both ventricles will displace the apex of the heart caudally and towards the left. However, enlargement of the right ventricle is suspected with convexity of the middle arch of the left heart border. As the right ventricle is not a border forming structure in the frontal projection, indirect evidence of right ventricular pathology is suspected whenever one observes convexity of the middle arch of the left heart border and abnormal pulmonary vascularity. Pulmonary valvular stenosis, left-to-right shunts and pulmonary arterial hypertension are the most common causes of convexity of the middle arch of the left heart border. Rarely, the ascending aorta may occupy the middle arch of the left heart border (in corrected transposition of the great arteries, for example). In some instances abnormal convexity of the middle arch of the left heart border is related to herniation of the left auricular appendage through a partial pericardial defect or to a non-vascular condition such as an enlarged thymus, tumor, adenopathy, etc.

The left lateral projection of the heart provides for the best profile analysis of the right ventricle. The closeness of the anterior heart border to the sternum is not a good sign of right ventricular enlargement. In patients with a narrowed anteroposterior diameter of the chest, the heart is close to or contacts the sternum. The left and right anterior oblique projections are not informative for the evaluation of right ventricular enlargement.

THE BEST VIEW for evaluating left ventricular enlargement is the left anterior oblique projection. In this view when the left ventricle is enlarged it usually overlaps and may project beyond the thoracic spine. The angle formed between the left ventricle and the left hemidiaphragm may become obtuse. The right anterior oblique projection is not useful for evaluating left ventricular enlargement. In the frontal projection the shape of the left ventricular arch may reflect volume (broad large arch) and pressure (rounding, short arch) hypertrophy.

Pressure hypertrophy of either ventricle may be radiographically silent. Physical findings and electrocardiography are usually more sensitive than conventional roentgenography for the establishment of right or left ventricular hypertrophy. However, volume hypertrophy of either ventricle modifies heart size and configuration and will exaggerate the convexity of these chambers.

Asymmetric enlargement of the ascending aorta may be seen with aortic valvular stenosis (poststenotic dilatation) and with syphilis. When the aorta becomes dilated and tortuous the descending aorta may project beyond the middle arch of the left heart border. In such instances, the right superior mediastinum may show a convex density usually caused by a tortuous dilated and/or displaced innominate artery. Arteriosclerosis dilates and at the same time elongates the thoracic aorta. As the thoracic aorta has a fixed position at the level of the aortic valve and at the aortic hiatus of the diaphragm, elongation will occur and will displace the aortic anteriorly, cephalically, toward the right, and dorsally, beyond the thoracic spine. Analysis of calcification at the level of the thoracic aorta is important. Dissecting hematoma, and lues (with ascending aorta calcification) cause characteristic findings. Pericardial, coronary artery and valvular calcification are best analyzed at fluoroscopy. The best view to separate mitral from aortic valvular calcification is the left anterior oblique view. Aortic valvular calcification will project in the center of the heart and will have a cephalocaudal (head-foot) motion. Mitral valvular calcification will project in the posterior third quadrant of the heart and will have a reverse C shaped motion.

PRINCIPALS IN the study now being evaluated of health behavior of Upper Peninsula residents and the health education programs in U.P. Schools include, from left, Richard Potter, M.D., health officer for the Marquette County Health Department; Gordon M. Labuhn, vice chairman of the Zone III Comprehensive Health Planning Council, and regional director for the U.P. Region of the Michigan TB and Respiratory Disease Association; Frank Mead, superintendent of the Alger-Marquette Intermediate School District, and Mrs. Thomas Mudge, chairman of the Zone III CHP Council and state mental health chairman for the Woman's Auxiliary to MSMS.

Follow-up Now Underway in U.P. Of Two Unique Health Studies of Residents

A follow-up is underway currently of two massive surveys of the health attitudes of 15,000 Upper Peninsula residents and the health education programs of 50 U.P. schools.

On March 6 the Health Education and Information Committee of the Zone III Health Planning Council of Marquette and Alger Counties began an expected year's review of the results of the two studies made in 1967 and 1968.

THE FIRST STUDY, called a Health Behavior Inventory by the Upper Peninsula Office of the Michigan TB and Respiratory Disease Association which initiated, financed and coordinated it, began in February, 1967, and was concluded in May, 1968.

A total of 751 teachers; 13,300 schoolchildren in grades 3 through 12; 466 parent members of PTAs, and 161 members of the general public were tested for their knowledge, practices and attitudes in health and personal well-being.

Schools, PTA groups, and community organizations were invited to participate as co-sponsors of the study. Thus, 28 community organizations, 46 schools, 21 PTA groups and two local congressmen committed themselves to its support.

Among them was the Alger-Marquette County Medical Society. It produced a half-hour television show during which the test, including questions on 11 major areas of health concern from nutrition to mental health, was given to persons watching.

The test itself was developed under the sponsorship of the National Education Association, the AMA, the U.S. Public Health Service, the U.S. Office of Education and the National Congress of Parents and Teachers.

In the second study, conducted in September, 1968, the Zone III CHP Council coordinated personal interviews of the principals of 49 schools to evaluate those schools' total health programs.

Physicians on the board of directors of the Zone III CHP Council at that time were James Tobin, M.D.; Leonard Carefoot, M.D.; Donal Conley, M.D.; E. W. Hoffman, M.D.; W. C. Humphrey, M.D.; Richard Potter, M.D., and David Wall, M.D.

Following completion of the two surveys, a total of 28 recommendations were developed by the Council's Health Education, Dental Health and Mental Health Committees. They were directed to 15 persons, groups and agencies in the Upper Peninsula for implementation.

The follow-up was started March 6, to determine progress on the recommendations and provide assistance where indicated or requested.

THREE INITIAL RESULTS of the studies are already noted by Gordon Labuhn, regional director of the U.P. TB and Respiratory Disease Association.

Two schools have written new forms to replace inadequate former procedures for action to be taken when a child is hurt at school. The Alger-Marquette Intermediate School District office has collected all movies, books, pamphlets and brochures on health available from state and national sources to provide a resource library for schools in the two counties.

Thirdly, notes Mr. Labuhn, the results of the health behavior inventory have been used for the writing of several grant proposals by George Hensley, director of paramedical programs for Northern Michigan University.

A Health and Nutrition Study Among Michigan Indians

BY WALTER C. WILLET
RALPH A. FOULKE
JOHN R. K. ROBSON, M.D.
WALTER D. BLOCK, PH.D.
ALL OF ANN ARBOR
LAWRENCE V. PERLMAN, M.D.
MILWAUKEE

Within the past few years there has been an increasing concern with the health and nutrition status of low income groups within the United States. While there have been a number of studies describing the urban poor[1] and western reservation Indians there is as yet no detailed, published survey regarding the health needs of Michigan Indians.

There are approximately 10,300 Indians living in Michigan, 1,200 of whom live on small reservations mostly in the upper peninsula. The Hannahville-Wilson community is one such reservation on which 20 families live approximately 15 miles west of Escanaba. In the summer of 1968 two medical students studied the health and nutrition of these families. The purpose of this report is to describe their findings.

METHODS

Arrangements for surveying the Indian community were made through the Delta-Menominee County Department of Health (Mary Cretens, M.D., Director) and Theodore Bash, M.D., whose office in Bark River provides for most of the medical needs of the Indian community. Mr. Joseph Sagataw, the tribal council chairman, was also consulted and gave his approval to the survey plans. He then arranged for the use of a community building for examinations.

The on-site investigation was done over a five-week period by two junior medical students of the University of Michigan-based chapter of the Student Health Organization. The students (W.W. and R.F.) received several weeks of training in clinical nutrition and epidemiology prior to their arrival in Bark River. Local supervision was provided by Doctor Cretens and Doctor Bash, and weekly reports were mailed or phoned to two of the senior authors (J.R. and L.V.P.). In addition, these authors visited Hannahville during the study for a period of direct supervision.

During the survey brief medical histories were completed on both adults and children with a particular emphasis on symptoms and/or history of diabetes mellitus, heart disease, and hypertension among the adults, and on birth weights, early development, illnesses, and hospitalizations among the children. Information on age and sex was obtained (**Figure 1**). Data was also collected on the number of pregnancies, abortions, stillbirths, infant deaths, and living children per family. Pedigrees were made for all families and then integrated into a total community pedigree.

Physical examinations were done on 31 of the 39 resident adults and on 60 of the 74 children with close attention being paid to any signs of malnutrition. Heights were measured with a vertical tape, weights were taken on a platform scale checked periodically with standard weights, and triceps and subscapular skinfolds were measured with a Harpenden calipers. Blood pressures were taken with "Tycos" aneroid sphygmomanometers similar to the method of Johnson and Remington, with the last three of six measurements being averaged.[2] Labstick urinalyses were done, and fasting blood samples were drawn on 30 adults and 46 children. The blood was shipped to the Nutrition Laboratory of the School of Public Health in Ann Arbor where cholesterol, triglycerides, pre-β lipoproteins, and glucose levels were determined. Detailed results of the blood lipid measurements will be published elsewhere.[3]

After completion of the Hannahville-Wilson study a nearby Caucasian population in Powers-Spalding was surveyed for purpose of comparison. This second survey, like the first, was greatly facilitated by two VISTA volunteers who located suitable subjects and scheduled their appointments.

Mr. Willet and Mr. Foulke are now fourth year medical students, University of Michigan. Dr. Robson and Dr. Block are with the Departments of Epidemiology and Health Development, the School of Public Health, The University of Michigan. Doctor Perlman, formerly with the Department of Epidemiology, University of Michigan, is now with the Department of Medicine, Marquette School of Medicine, Milwaukee.

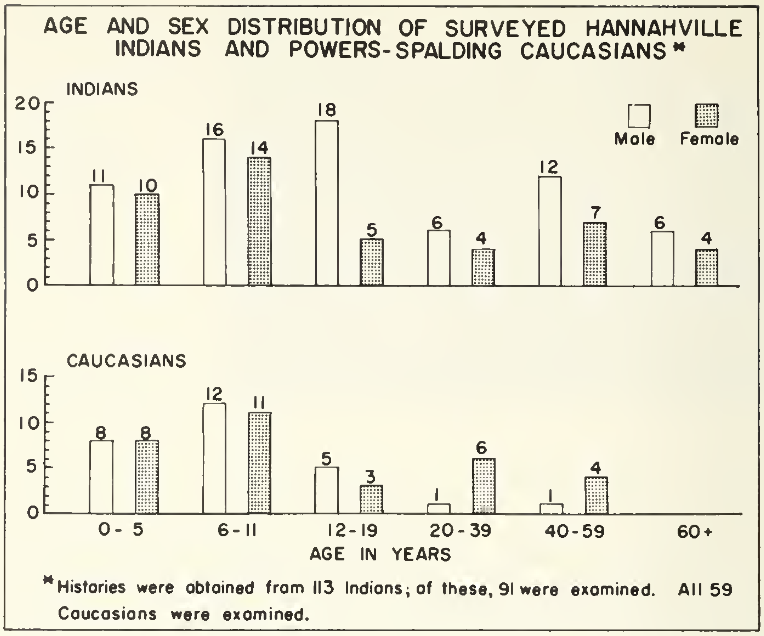

Fig. 1 Age and sex distribution of surveyed Indians and Caucasians.

The group was similar to the Indians with respect to age and sex up to the age of 19; however, fewer adults participated. Also, this population was not as socio-economically homogeneous as the Indians because families of farmers, construction workers, woodsmen, and welfare recipients were represented. Altogether 47 children and 12 adults were examined. (**Figure 1.**) The number of adult Caucasians, however, was too few for meaningful comparison with adult Indians. Fasting blood samples were drawn from 44 children and 12 adult Caucasians, these results will be reported elsewhere.[3]

Immediately following the return of the students to Ann Arbor, two research nutritionists of the University of Michigan School of Public Health (Dr. F.A. Larkin and Anita Sandretta) conducted diet analyses within these same two groups. Household members were asked what foods they consumed during the previous day. This information was recorded in terms of frequency of foods consumed per person per day, and the two groups were then compared. No attempt was made to determine true quantitative food intake by this 24-hour recall method.

HISTORY AND COMMUNITY SETTING OF HANNAHVILLE-WILSON INDIANS

By 1883 the Potowatomi Indians had ceded all their Michigan lands to the United States government. In return, land was offered to them, and in 1836 a forced migration to Kansas was attempted. Some Potowatomi fled to the Wisconsin territory and later moved northward into the Upper Peninsula of Michigan. By 1883 these Indians arrived near the Hannahville-Wilson area where they settled and in 1913 the United States Congress granted them 3,359 acres. The Potowatomi have remained on this land ever since and are among the most racially pure of Michigan Indians.[4]

The estimated population of the Hannahville-Wilson community during this survey was 113; 74 of these being under 21 years. The median age for both males and females was 14 years. An accurate census is difficult because families and individuals periodically move off the reservation seeking employment, and because children often spend protracted periods visiting relatives in Milwaukee, Chicago, and elsewhere. Common reasons for returning to the reservation are to receive free medical care, to obtain welfare benefits, or to be with one's family when outside employment is no longer sought.

Of the adult men living in the community only one, the tribal chairman, has regular outside employment. The others are either employed under the Title V program of the Office of Economic Opportunity and thus engaged in remodeling or constructing dwellings in the community, minimally employed elsewhere, or retired. Several of the men are woodsmen cutting pulpwood for nearby mills, and many individuals and whole families are seasonably engaged in cutting cedar branches used in the manufacture of Christmas and funeral decorations. Governmental financial assistance supplements these limited incomes, and government surplus food is distributed monthly.

English is spoken by all residents, traditional language and culture being almost entirely absent. Indigenous government is composed of an elected tribal council with the tribal chairman as head.

There are 18 wooden houses and three large housetrailers used as dwellings in the community. All are severely overcrowded by usual standards. The dwellings are without inside plumbing or telephones. Part of the current Title V program is to install electric water pumps and inside plumbing which has been universally absent until this time. The Hannahville area has had electricity for about two years, but the nearby Wilson area is yet to be electrified. About 78% of the families own television sets and 45% own cars.

The dwellings are widely spaced, often not within sight of each other, and the lands surrounding them are wooded and not cultivated. The road into Hannahville has recently been paved and provides adequate access to public schools and outside commercial centers; cars and hitch-hikers are common. Although the community is becoming less isolated physically it remains very isolated socially, and inbreeding has been extensive for generations.

Free medical care for the community is provided under a United States Public Health Service contract with a local physician whose office is in nearby Bark River. Federally paid hospitalizations are arranged in Escanaba.

RESULTS

A. **Infant Health** In the Hannahville-Wilson community* there were eleven families who still have children at home. The average number of children in these families is 8.8. In the last 20 years there have been 109 pregnancies of which 97 were live births. Twelve pregnancies terminated in abortions resulting in an abortion rate of 11.0%. Four of the 97 live births died within one year, leading to an infant mortality rate of 41/1,000 births. Birth weights of Indian children (N = 54) averaged 8.2 pounds and those of the Powers-Spalding Caucasians (N = 43) also averaged 8.2 pounds. (Table I)

TABLE I
INFANT HEALTH

	Hannahville Indians	Powers-Spauling Caucasians	National
Infant Mortality/1000 live births	41 (97 births)	—	25.2[7]
Spontaneous Abortion	11.3% (97 births)	—	10-15%[17]
Birth Weights	8.2 lbs. (54 births)	8.2 lbs. (43 births)	7.45 lbs.[18]

B. **Child Health** The distribution of heights and weights of the examined Indian children is shown in Figure 2. Of the children under the age of six, 13 of 15 (87%) were at or above the 50 percentile in weight and 11 of 15 (73%) were at or over the median in height as defined by the 1965 study of Tanner *et al.*[5] From six to 11 years of age there is a slightly increased percentage of boys with heights and weights less than the 50th percentile. Above the age of eleven, boys were again heavier than the median; skin fold measurements showed this might be due to fat deposition rather than muscular development.[6]

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*The terms Hannahville and Hannahville-Wilson are used interchangeably in the text.

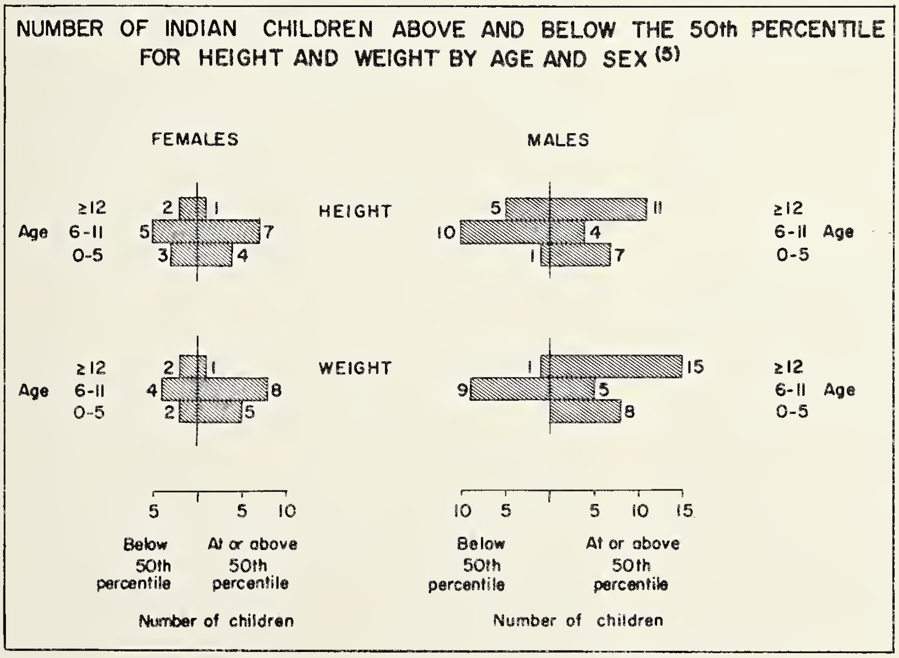

Fig. 2 Height and weight distribution by age and sex for Indian children.

TABLE II

FREQUENCY OF CHILD HOSPITALIZATIONS

	Hospitalizations (number since 1953)	Hospitalizations per 1000 children annually
Hannahville Indians (N = 60)	78	183
Powers-Spalding Caucasians (N = 47)	31	89
National Average [11]	—	67

An eczematous dermatitis was noted in three of 75 children examined. All three were girls who gave a history of onset at about six years of age. Seasonal excerbations are noted in spring and summer leading to repeated hospitalizations and abscences from school. The rash was observed only on exposed areas and the facial distribution was that of a sun sensitivity. The role of sensitizing soaps, skin creams, foods, or other agents in provoking such reactions could not be determined. The possibility of a pre-pellegra state cannot be excluded.

One child had had open heart surgery for a ventricular septal defect while another was suspected of having chronic renal disease. Juvenile diabetes was not detected in any of the children studied. Prevalence data were not collected on any other childhood conditions.

Indian children had been hospitalized at about three times the national rate and over twice that of the Powers-Spalding whites (**Table II**). The most common causes for hospitalization of Indian children were respiratory infections, digestive disturbances, and surgery (**Table III**).

Indian children had had more dental caries than the local whites studied, but received more dental care. The Caucasian children exhibited twice as many unfilled caries as the Indian children. The Indian children, on the other hand, had more than twice as many filled caries (**Table IV**).

C. **Adult Health** Of the 39 adult Indians studied (average age 49 years) five were known diabetics and were on oral hypoglycemic agents. Three more were suspected diabetics on the basis of elevated fasting blood sugars and glucosuria and were later confirmed to be diabetic by abnormal glucose tolerance tests. This total of eight gives an adult prevalence rate of 20.5%. By history seven adults (18%) had been treated in hospitals for pulmonary tuberculosis and five (13%) had had peptic ulcers (**Table V**). 31.6% of the males and 57% of the females were 20% or more above the average weight for their height, age, and sex (**Table VI**).

Among these 39 adults there were four persons (10%) with hypertension (160/95 or greater). One male reported a myocardial infarction, which could not be confirmed.

TABLE III

REASONS FOR CHILD HOSPITALIZATIONS

	Hannahville Indians		Powers-Spalding Caucasians	
	No. of hospitalizations	Percent of Total	No. of hospitalizations	Percent of Total
Respiratory	32	41%	11	32%
Diarrhea, Dysentery, Feeding Problems	13	17%	3	10%
Trauma	4	5%	0	—
Dermatologic	9	12%	0	—
Tonsillectomy	6	8%	7	23%
Appendectomy	1	1%	3	10%
Ear Infection	2	3%	0	—
Other	11	14%	7	23%
	78	100%	31	100%
Surgical	16	20.5%	12	39%
Non-surgical	62	79.5%	19	61%
	78	100.0%	31	100%

DISCUSSION

A. **Infant Health** The infant mortality rate over the last 20 years in Hannahville has been 41/1,000. It is difficult to compare this with the national rate of infant mortality because it is computed annually while the rate in Hannahville was determined over a 20-year period. Within this 20-year period the national infant mortality rate fell from 32/1,000 in 1948 to 25.2/1,000 in 1963.[7] Thus it appears that Hannahville's infant mortality rate is higher than the national average. However, it is not possible to be certain about this tendency because the infant mortality rate in Hannahville is based on small numbers.

Indian birth weights, as well as the abortion rate, on the other hand, imply a maternal-child health level that is not distinctly different from the national norm. The average Indian birth weight of 8.2 pounds (not all of which were confirmed by certificate) is higher than the national average of 7.45 pounds, and the abortion rate of 11% compares favorably with the 10-15% national rate.

B. **Child Health** On the basis of the anthropometric data, which showed normal patterns of growth, and the normal physical examinations, there is little to support the presence of any protein-calorie malnutrition. The reason for the decreased height and weight of the six to 11 age group is not clear. One hesitates to make inferential statements when the number of subjects surveyed is so limited. Moreover, the role of race in determining height and weight is uncertain because it is difficult to find groups of middle class Indians so that height-weight comparisons can be made which do not depend on social class and

TABLE IV

DENTAL STATUS OF CAUCASIANS AND INDIANS (AVERAGE PER CHILD)*

	Decayed	Missing	Fillings
Hannahville Indians (N = 46)	1.0	1.4	2.2
Powers-Spalding Caucasians (N = 38)	2.1	1.4	5.6

*Data on dental status is available on 76.7% (46 of 60) of the Indian children and 80.8% (38 of 47) of the Caucasian children.

TABLE V

CHRONIC ILLNESSES AMONG ADULT HANNAHVILLE INDIANS

	Hannahville Indians N = 39*		General American Adult Population
	Number with Condition	Percent with Condition	Percent with Condition
History of TB	7	17.9%	—
Obesity	14*	42.4%	8.5% [19]
History of GI Ulcer	5	12.8%	10.0% [20]
Hypertension	4	10.3%	15.9% [21]
Diabetes	8	20.5%	1.5% [22]

*Data on weight is available on 84.6% (33 of 39) of adult Indians.

economic status. A study of Blackfoot Indians did indicate that children developed normally according to the Iowa Growth Charts until the age of five, and above average beyond that age.[9]

The eczematous, sun-sensitive skin rash found in the three girls has not been described previously in Michigan Indians, and had not been recognized as an entity common to Indians by the local medical community. Similar cases have been observed in Red Lake, Minnesota and among Canadian Indians. Examination of 64 cases in Manitoba revealed seasonal variations in incidence; no porphyrin abnormalities or etiologic factors could be identified.[10] Further investigation of this dermatologic problem seems warranted.

The high hospitalization rate of the Indian children studied is consistent with the results of the 1966 National Health Survey which indicates that the frequency of hospitalizations tends to decrease as income rises. (The number of hospital discharges annually per 1,000 people decreased from 131.8 to 114.7 as annual incomes rose from $3,000 to greater than $7,000. This same survey also showed that length of hospitalization decreases as income increases.) [11]

The reasons for the high rate of hospitalization among Indian children are many. Indigent parents may be less likely to bring a child to the doctor for a minor illness, but instead delay until an illness is more advanced.[1] In Hannahville part of this tendency to delay may be explained by the lack of telephones which are used commonly in routine pediatric care. Moreover, hospitalization imposes no financial burden on the Indian family, and the overcrowded home is less than desirable for the care of sick children. Because of these factors physicians are less hesitant to hospitalize Indian children. 53% of the national hospital discharges for children under 15 years involved surgery;[12] only 20.5% of the admissions for the Indian children of Hannahville were for surgical reasons. These data suggest that some of the Indian hospitalizations could have been treated on an out-patient basis under improved social conditions.

Social factors may also have influenced the prevalence of dental caries. The Indian children had more treated caries and fewer untreated ones than the Powers-Spalding children. The Indian diet and lack of strict dental hygiene may be a factor in the increased number of Indian caries. Yet removal of financial barriers through Federal assistance allowed for most of these increased needs to be met.

C. **Adult Health** The high prevalence of diabetes mellitus among these Indians, 20.5% of all adults, is consistent with findings in other Indian groups.[13,14] Prevalence values from 5.3% to 49% have been reported in various adult Indian studies. In one of these, a group of the Cherokee of North Carolina in which glucose tolerance tests were used, a prevalence rate of 24.3% was reported.[13] Obesity, diet, and heredity all play probable roles in the etiology of diabetes. Among the Hannahville Indians as in other Indian groups studied it is difficult to establish the exact contribution of each of these factors.

Of the eight diabetics reported in the survey, all of adult onset type, three were at least 20% above the standard for weight as determined by their height and sex, and six were at least 10% above the standard.

Various studies have shown American Indian diets to be high in starches and fats and low in dairy products, fruits, and vegetables.[14] Similarly the dietary interviews completed by the two nutritionists at the conclusion of this survey demonstrated limited sources of ascorbic acid, e.g., fresh fruits and vegetables in the Hannahville diet. Milk intake also seemed inadequate. A high carbohydrate and high animal fat intake was substantiated by an investigation into the amount of surplus commodity foods distributed to the families.[6]

The high percentage of Hannahville Indians having histories of tuberculosis is consistent with the high prevalence among Indians elsewhere. In 1964 American Indians had an incidence for this

TABLE VI

RELATIVE WEIGHTS OF ADULT HANNAHVILLE INDIANS* (PERCENT OF "STANDARD WEIGHT"[19]

	less than 90	90-120	greater than 120
Percent of males	21.0	47.4	31.6
number	(4)	(9)	(6)
Percent of females	14.3	28.7	57.0
number	(2)	(4)	(8)
Percent of adults studied*	18.2	39.4	42.4
	(6)	(13)	(14)

*Data on weight is available on 86.4% (33 of 39) of adult Indians surveyed.

disease of 184 per 100,000 population, about seven times the rate of all United States races.[15] Hannahville Indians with tuberculosis are followed by the County Health Department. There was in fact one new case discovered during the survey; contacts of this were studied for evidence of tuberculosis infection. Cardiovascular disease, on the other hand, was limited to one reported case of myocardial infarction and four cases of hypertension. Although these figures are small, they too correspond with findings among other Indian groups in which very low myocardial infarction rates were reported.[16] However, electrocardiographic studies were not preformed and it is difficult to be certain about the prevalence of cardiac disease in this population without such determinations.

The high rates of hospitalization and dental caries among the children and of obesity, diabetes, and tuberculosis among the adults of the Hannahville-Wilson community are conditions which are amenable to improvement. A greater emphasis on health and nutrition education and preventive medicine are the means by which such improvements in health might be accomplished. Moreover, since health is related to the Indian's poverty status, improvement in his socio-economic status may bring improvement in his health.

It is with this realization that the Hannahville Community Hall is being remodeled to become a year-round Head Start facility and adult homemaking center. The Title V program directed toward home improvement and adult employment as well as the VISTA volunteer efforts in community organization are two more programs which have health-care significance. It would be of interest to inspect the effects of these and similar programs on the health of the community in the future.

CONCLUSIONS

The Hannahville-Wilson Indian community of Michigan was studied with respect to nutrition and health status. No definite conclusions could be made about the infant mortality rate because of the small numbers involved. Indian birth weights and the abortion rate imply a level of maternal-child health that is not distinctly different from the national average. Indian children were born heavier than the national average and continued to be both heavier and taller in the early years, but reached adulthood shorter in stature and with a higher proportion of body fat, resulting in obesity. There were no physical findings definitely suggestive of nutritional deficiency. Indian children exhibited a higher rate of hospitalization and a higher prevalence of dental caries than did a nearby Caucasian group. The Indian adults surveyed exhibited a higher prevalence of diabetes mellitus, obesity, and a history of tuberculosis than is reported for the United States as a whole. Further amelioration of the health status of the community will depend on improved health and nutrition education, preventive medicine, and advancement in socio-economic status.

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The following paper is reprinted from "Clinical Research, 1969," with the permission of Hugh Hussey, M.D., who is director of Division of Scientific Activities, the American Medical Association. We feel that the facts as presented by Dr. Hussey will stand by themselves but would like to emphasize that the A.M.A. represents physicians in the United States who have an active interest in the welfare of the people of the United States and also an interest in the socio-economic development which would mitigate against the care that these people should have. The House of Delegates of the A.M.A. represents the physicians of the United States against outside influences and outside organizations which would change the pattern of practice which, at the present time, has generated the help which the people of this country need for their health care.

The A.M.A. is looking to tomorrow and does not wish to preserve only the faults of yesterday. It is only by making the A.M.A. and its constituent societies stronger that these dreams can materialize. The very fact that there are 53,000 physicians in the United States who are eligible to be members of the A.M.A. and who do not now hold membership indicates that there are many in our midst who do not understand the great value that the A.M.A. holds, not only to them, but to the people they serve. We trust that the article by Doctor Hussey will make interesting reading and will also stimulate many who do not now belong to our organization to join.

Donald N. Sweeny, Jr., M.D.
Chairman
MSMS Delegates to the AMA

The AMA—Why Belong?

BY HUGH H. HUSSEY, M.D.

The title's question derives from the fact that the Editor of *Clinical Research* has said that he is often asked by his peers—the younger representatives of Academe—about joining the AMA. Presumably, they ask the question in a negative tone—the AMA, who should want it?

The question is not a new one. For years it plagued the founders of the Association until, in 1847, they succeeded in its establishment. Their objectives were clear. They desired to promote medical science (what there was of it) and concurrently to combat charlatanism and quackery (of which there was plenty). They were concerned with the existing programs of medical education (most of which were horrendous). They sought uniformity in the ethics of their profession.

It is reasonable to assume that during the latter half of the 19th century, the question "Why belong?" continued to be asked, but for different reasons than prevail today. Then the non-joiners may have been wondering "What will the Association do *to* me?" Now, I assume the non-joiners are wondering "What will the Association do *for* me?" The question can be answered pragmatically by listing the benefits of membership all of which relate to the Association's original objectives. Another approach is possible.

There are two types of membership in the American Medical Association—active and special. Quoting from the Bylaws of the Association, "Active Members shall be Regular or Service."[1] A regular member is one who holds the rights of membership in his state association and has paid his dues to the AMA (unless exempted). Of course, county association membership is a prerequisite to state association membership (except in places like the District of Columbia, where there are no counties). Service members are physicians in the uniformed services and the Veterans Administration. Definitions of special members are irrelevant to the purpose of this essay.

Some recent accounts have given the impression that the proportion of physicians who are AMA members is shrinking. The true story is that there are currently 208,000 members of state medical societies, of whom 191,000 are regular members of the AMA (+91%). In addition, there are 20,000 service members. Thus, total AMA membership is 217,000—an all-time high.

The total MD population in the United States is about 317,000, of whom more than 47,000 are serving as interns and residents. Few in these groups are likely to be AMA members. This implies that about 53,000 MDs who *might* be

TABLE 1—COMMITTEES OF THE AMERICAN MEDICAL ASSOCIATION*

Faculty Status of Committee Members

Division	Number of Committees	Full-time (Dean)	Full-time (Prof.)	Full-time (other)	Part-time	None
Scientific Activities	17	3	49	14	48	40
Health Service	14	2	27	8	33	91
Scientific Publications	10	2	87	8	4	19
Medical Education	7	9	12	3	8	14
Law	5	0	2	1	6	16
Communications	1	0	2	1	6	0
Public Affairs	1				3	9
Totals	55	16	179	35	108	189

* Councils, committees, commissions, advisory boards.

eligible to be members of the AMA do not hold membership. Of that number, how many are MD full-time members of medical school faculties?

The answer: no one really knows. It is estimated that about 50% of MDs in Academe are active AMA members, with a range of 20% to 80% among the medical schools.

The estimate of 50% can be partly substantiated by analysis of the Association's committee* structure. In order for a physician to be appointed or elected to a committee of the AMA, he must be a regular member of the Association. At the time of this writing, 55 standing committees can be identified, with a total membership of 527. **Table 1** displays the extent of academic participation in the committees staffed by seven of the Divisions of the AMA. Thus, 230 committee members are full-time academicians, 108 have a faculty appointment of some kind, and 189 have no faculty affiliation. This activity of academicians in the committee structure of the Association is greatly beneficial and influential.

The foregoing exposition of data leaves unanswered the Editor's concern. At the last Teaching Institute of the Association of American Medical Colleges (Colorado Springs, 1962), I identified two groups of physicians—nonacademic practicing physicians and academic practicing physicians—whose different settings in society cause them to have different views of societal problems and therefore different value systems.[2] At that time, I was considering the potentiality for controversy as a result of their intersection of interest in medical practice. However, even in the absence of overt controversy, it may be that their different view of societal problems explains their failure to be involved in "organized medicine." Perhaps they consider that it has little to offer them, or it may seem inimical to their interests and objectives.

There are other reasons for the failure of academicians — especially younger academicians — to become "involved." Some are ineligible for county or state society membership because of what I consider anachronisms in society constitutions and bylaws. Lacking "local" membership, physicians are automatically excluded from "national" membership. (As a federation of state, commonwealth, territorial, and insular medical societies, the AMA does not provide access to "direct" active membership except in the instance of "service members.")

At one time, financial considerations may have influenced younger academicians; they may have been unable to afford dues to county, state, and national coffers, the least of which is the "national." Some may still excuse themselves for this reason. When they do so, probably they are expressing disinterest more than lack of funds.

In some areas, local societies may discourage or at least not encourage academicians to obtain regular membership. However, this is probably a minor factor.

There are strong reasons to recruit full-time faculty physicians to membership in the AMA. They are needed in the deliberations of "organized medicine" at all levels—local and national. Their voices may have a different ring than that of the "in-group." So much the better. As Freymann has written, "The genius of the democratic system rests on the ability of opposite extremes to modulate each other. *A strong minority can do this as effectively as a majority*."[3] No better proof can be found than in the *Report of the Commission on Research*.[4] For years, much to the dismay of the academic community, the AMA had opposed direct Federal support of medical education except in the nature of funds for construction. The Commission on Research had eight members, of whom six were physicians, four of them academicians. Recommendation 13 of the Commission's report stated in part, "The imbalance between biomedical research and education, caused by the heavy, but desirable, Federal support of research, should be corrected by supporting measures that will materially increase both private and public funds for the support of the educational programs of the medical schools." That "minority voice" prevailed; AMA policy was indeed modulated.

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* *Committee* is used generically. The term includes committees, councils, commissions, advisory boards.

It is too much to hope that anything printed herein will influence academicians, old or young, to join the ranks of "organized medicine." There is another, more effective, influence available. In the spring of 1969, ten Senior medical students from a Chicago medical school visited AMA Headquarters, ostensibly to learn something about the AMA. At the outset, they were openly hostile. They rejected the idea of the formal program that had been prepared. For several hours, they shot questions at staff members of the Divisions of Medical Education, Scientific Activities, and Communications. They left the building not only satisfied that the AMA is dedicated to the purpose enunciated by its founders, but convinced that if the Association has faults, they have an obligation to work *within* "organized medicine" for its betterment.

That experience permits me to conclude with—

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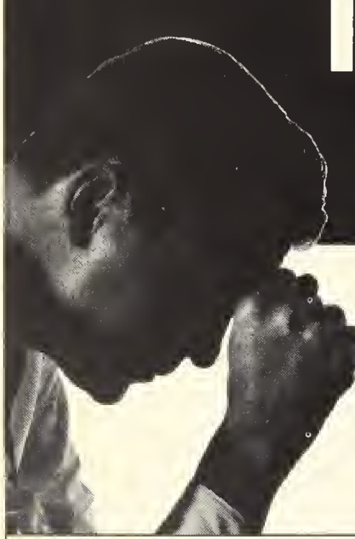

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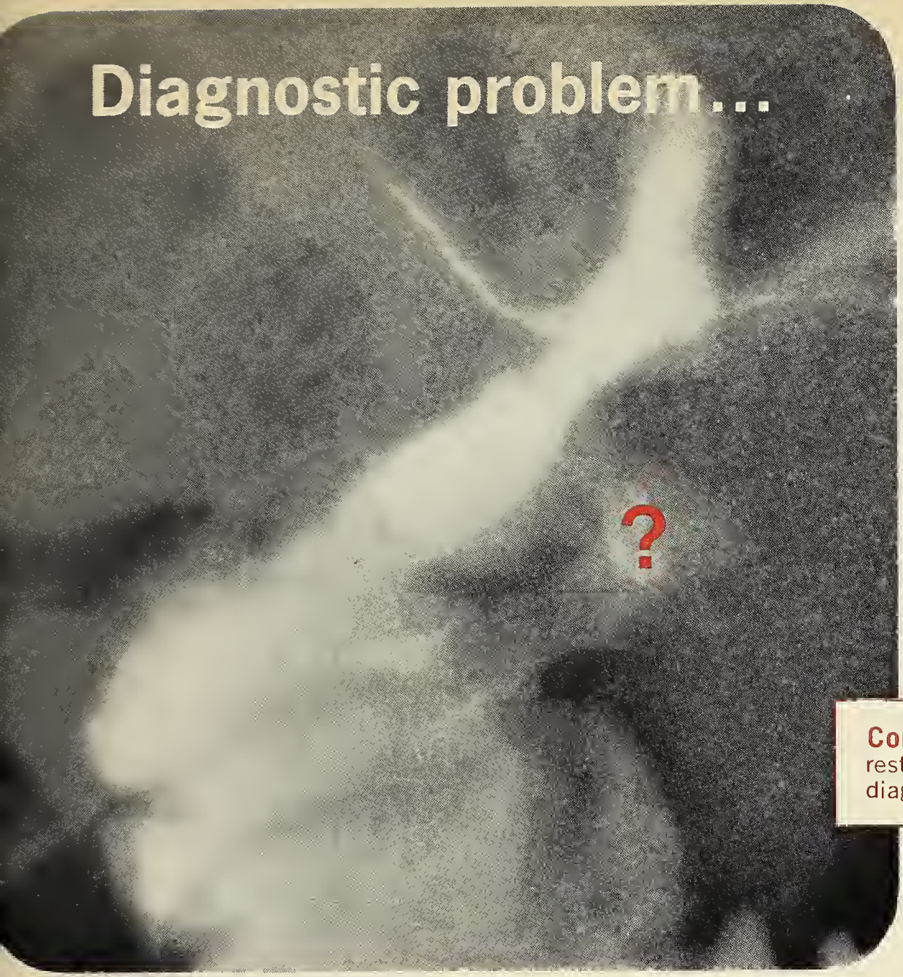
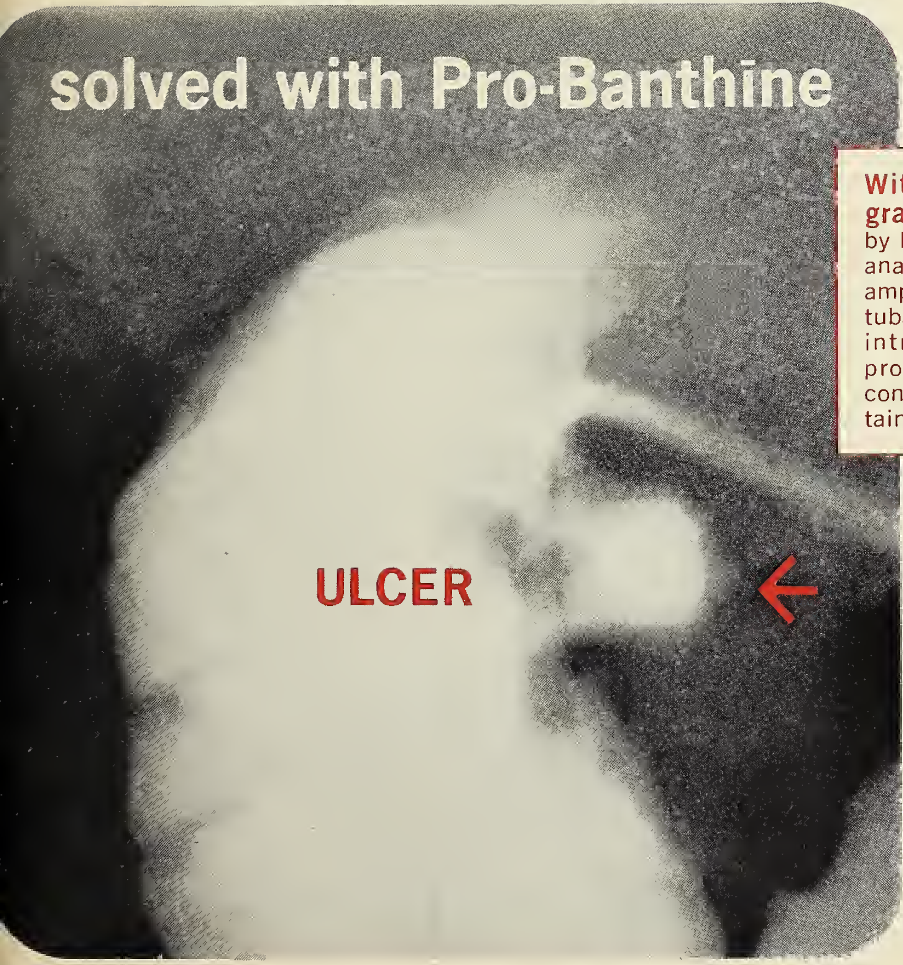


Conventional x-rays of the restless duodenum are often diagnostically indefinite.

solved with Pro-Banthīne



With hypotonic duodenography duodenal calm induced by Pro-Banthīne permits clear anatomic appraisal. In this example the duodenum was intubated. Pro-Banthīne, 60 mg. intramuscularly, produced prompt aperistalsis. Double contrast visualization was obtained with barium and air.

Nose clear as a whistle

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Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

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In dermatologic disorders...

the
advantages
of
ALLERSONE
OINTMENT
in
dermatologic
disorders

antiinflammatory
▪
antipruritic
▪
antiallergic
▪
anesthetic

IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE

OINTMENT

for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.

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hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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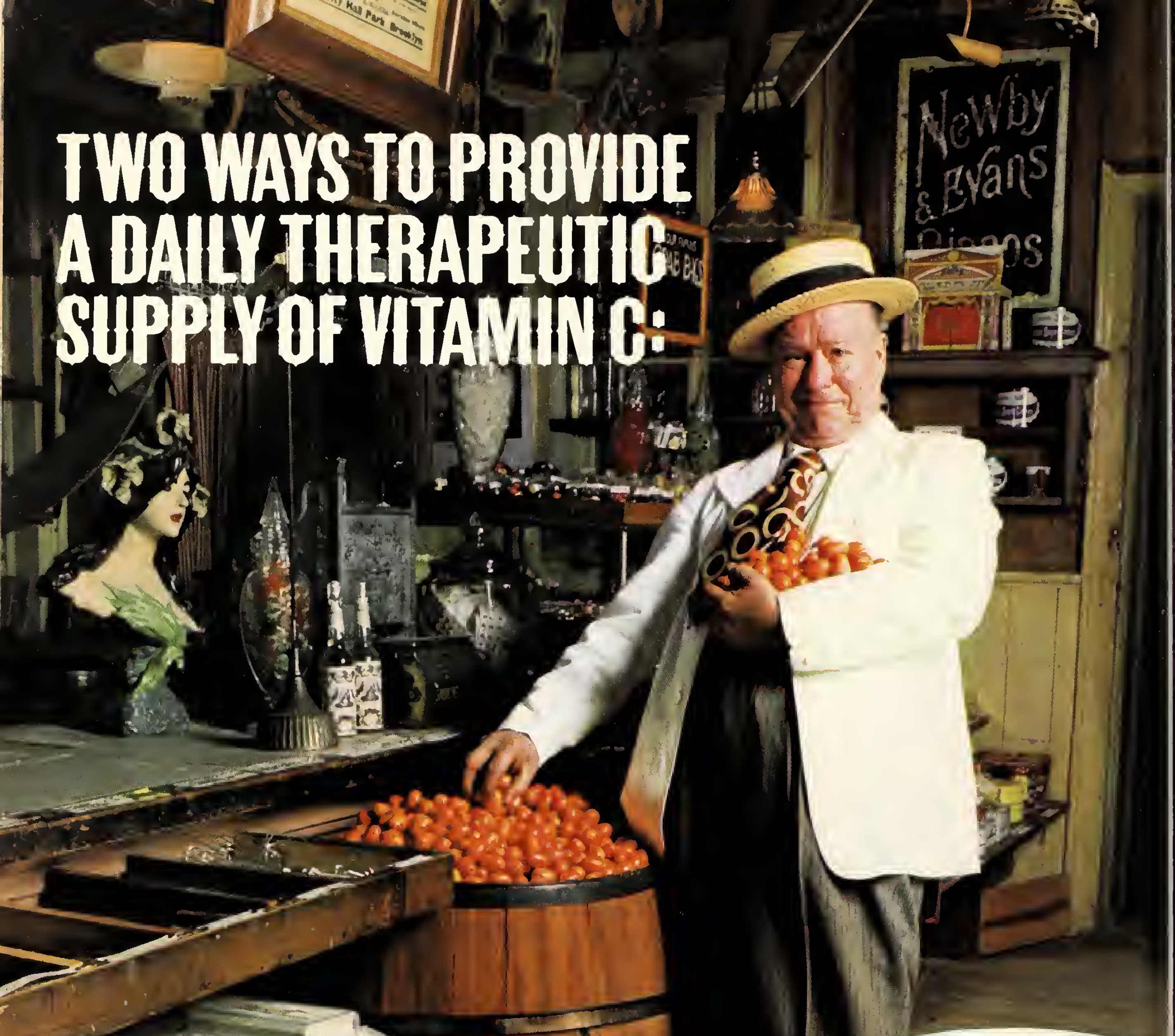
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Your patient would have to eat 1,500 kumquats a month, about 50 a day, to get as much Vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). Allbee with C is a lot easier to come by too. Unlike kumquats, it's always in season. In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. The handy bottle of 30 gives your patient a month's supply at a very reasonable price. Economy size of 100 also available. At pharmacies on your prescription or recommendation.

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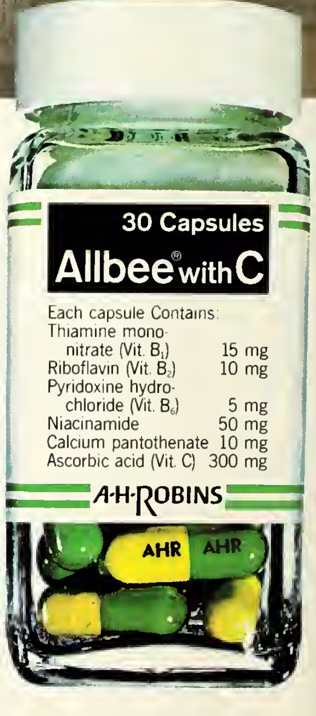
30 Capsules
Allbee® with C
Each capsule Contains:
Thiamine mononitrate (Vit. B1) 15 mg
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msms news

Michigan Mediscene

April 6 — Annual WCMS Beaumont Lecture, WCMS Headquarters

April 10-16 — Annual Michigan Hospital Week

Apr. 22 — MSMS Council, Towsley Center, Ann Arbor, 9:30 a.m.

Apr. 23-26 — Michigan State Medical Assistants Society Annual Meeting, Pontchartrain Hotel, Detroit

April 25 — Medical Careers Conference at Detroit Rackham Building

Apr. 30 — 1970 MSMS Conference on Medical Aspects of High School Sports, Towsley Center, University of Michigan, Ann Arbor

May 6-8 — Michigan Public Health Association Annual Meeting, Statler-Hilton Hotel, Detroit

May 12-14 — Medical Staff-Trustee-Administrator Forum, Sponsored by Michigan Hospital Assotion, Boyne Mountain Lodge

May 15-16 — Michigan State Association of Industrial Nurses, Spring Conference, Holiday Inn, Midland

May 16 — 15th Annual All-Day Scientific Session, Michigan Society of Anesthesiologists, Sheraton-Cadillac, Detroit

May 18 — Annual Conference for Medical Reporters and Yates Lecture, Michigan State University

May 21-22 — MSMS Annual Maternal Health Conference, Kellogg Biological Station, Gull Lake

May 27 — MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

June 17 — MSMS Special Council Meeting, MSMS Headquarters, East Lansing, 12:00 noon

June 21-25 — Many Michigan physicians will attend The AMA Annual Convention in Chicago.

July 23-25 — MSMS Midsummer Session of The Council, Grand Hotel, Mackinac Island

July 23-25 — Midsummer Meetings of Medical and Health Organizations of Michigan, Grand Hotel, Mackinac Island

Sept. 20 — MSMS Council, Sheraton-Cadillac Hotel, Detroit, 9:30 a.m.

Sept. 20-24 — MSMS Annual Session, Sheraton-Cadillac Hotel, Detroit

Sept. 23 — MSMS Council, Sheraton-Cadillac Hotel, Detroit, 8 a.m.

Oct. 16-17 — Michigan State Association of Industrial Nurses, Fall Conference, Holiday Inn, St. Joseph

Nov. 4 — MSMS Special Council Meeting, MSMS Headquarters, East Lansing, 12:00 noon

Nov. 11 — Michigan Cancer Coordinating Committee, MSMS Headquarters, East Lansing, 12:00 noon

Nov. 29-Dec. 2 — American Medical Association Clinical Convention, Boston

Dec. 9 — MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

MSMS Members Urged To Seek New AMA Education Award

MSMS members are being encouraged by the MSMS Committee on Postgraduate Medical Education to apply for the new AMA Continuing Medical Education Award.

Action to urge MSMS members to apply on a voluntary basis for the new AMA certificate was recommended by the MSMS Committee at a recent meeting and concurred on by the MSMS Council. Ross V. Taylor, M.D., Chairman of The MSMS Council, has asked the MSMS Committee on Postgraduate Medical Education to support this "voluntary AMA program of recognition" and to study the possibilities of closer MSMS involvement. The matter will be placed on the agenda for the next MSMS Committee meeting.

MSMS MEMBERS, WIVES INVITED TO ORIENT

Members of the Michigan State Medical Society and their wives are invited to take part in an Orient Adventure group tour to Japan and Hong Kong leaving Oct. 5 immediately following the MSMS Annual Session in Detroit.

A formal invitation and brochure were mailed to all MSMS members around April 1, describing the tour which was approved at the Dec. 10 meeting of The Council.

The tour will include 14 days in Japan and Hong Kong with transportation aboard a 707 jet, for the price of $898 per individual. Included are the air fare, meals, hotel bill, tips, hosts to escort the visitors throughout the trip and to arrange sightseeing, shopping, golfing and nightclubbing in Japan and Hong Kong, and a complimentary cocktail party the first night in Hong Kong.

council minutes

Meeting of Jan. 28, 1970

Forensic Medicine, Sex Education, Council Topics

BLUE SHIELD REPORTS — The Council decided that each Council meeting when Michigan Medical Service makes a report, the MSMS representative (Ralph R. Cooper, M.D., Detroit) will report in advance of the Blue Shield report.

BUDGET — The Council approved including depreciation funding as an annual budget item, agreeing that the present depreciation schedule would be followed but that changes might be appropriate at a later date.

WASHINGTON TRIP — The Council authorized a budget allocation of $1,130 to include the expenses of three officers and two staff attending the MAP Breakfast for Congressmen, April 27-28, and half the expenses of two MSMS representatives to the Feb. 27-March 1 AMPAC meeting in Chicago.

MEDIA SERIES — The Council authorized a 1970 budget allocation of $14,000 for the radio and newspaper series prepared by Mr. Brenneman.

FORENSIC MEDICINE — The Council approved establishment of a new Ad Hoc Committee on Forensic Medicine, in the belief that there are vital projects for such a committee to study and undertake.

HOSPITAL PRIVILEGES — The Council authorized the Hospital Privileges Committee to proceed with its proposed survey of the MSMS membership on the subject of hospital privileges, and limited the Finance Committee expenditure for the purpose to $1,000.

MEDICAL ADVISORY COMMITTEES — The Council approved seven guidelines, as clarified by the County Societies Committee, for Regional Medical Advisory Committees, and approved sending the guidelines to Regional Medical Advisory Committee chairmen.

NURSING HOME PATIENTS — The Council approved sending a letter, as edited and approved by the County Societies Committee, to Hermann Ziel, M.D., suggesting that local health departments work with county medical societies to select an M.D. to review the appropriate level of medical care for public assistance patients in nursing homes, and also suggesting that county medical societies should assign an appropriate committee to assist the selected physician in his work.

LEADERSHIP CONFERENCES — The Council approved holding a maximum of five one-day conferences at MSMS headquarters on various health subjects between Jan. 31 and July 31.

MSMS INSURANCE — The Council approved a request by the Committee on Professional Insurance Plans to increase the group life insurance available to MSMS members, since such an increase is now permitted by an amendment to the Michigan Insurance Code.

PSYCHIATRIC SERVICES — The Council decided to defer, pending further study by the reference committee, a request that MSMS approve in principle the American Psychiatric Association guidelines for psychiatric services covered under health insurance plans.

POPULATION CONTROL — The Council approved requesting Michigan Blue Shield to consider paying for the voluntary sterilization of certain individuals, in the face of the population explosion and the great need for methods of control.

DETROIT DMIC PROJECT — The Council approved writing letters to appropriate persons on the federal, state, county and city levels urging continued financial support of the Detroit Maternal and Infant Care Project.

SEX EDUCATION — The Council approved "Guidelines for the Teaching of Sex Education," a position statement of the Committee on Maternal and Perinatal Health.

CHIROPRACTIC — The Council agreed to recommend to HEW that it institute the necessary changes incorporating Title XVIII restrictions in the Title XIX plan, since the Department of Social Services has stated that it must reimburse chiropractors under the Title XIX program.

AMA DELEGATION — The Council expressed its appreciation to the MSMS Delegation to the AMA 1969 Clinical Convention in Denver, with specific commendation to Donald N. Sweeny, Jr., M.D., Detroit, for his able leadership of the delegation.

"All Interns are Alike"

stands to reason. They all go through the same train- g; they all have to pass the same tests; they all have measure up to the same standards; they all are nderpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more onsensical than what some people say about aspirin. amely: since all aspirin is at least supposed to come p to certain required standards, then all aspirin blets must be alike.

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You might also say that all interns aren't alike, either.

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CHILDREN'S
ASPIRIN
NEW!
CHILD-GUARD CAP
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MAILBAG

Michigan Medicine invites letters of 300 words or less for publication. Communications should be addressed to the Publication Committee, Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823. Unsigned letters will not be considered; but signed letters will be printed anonymously if the author so requests.

Himler Report Issue Brings Many Responses

(A number of responses have been recorded to the printing of a condensation of the Himler and Budd Reports to the AMA in the February News Extra of MICHIGAN MEDICINE.

A Texas physician who is president of his county medical society called MSMS Headquarters requesting to buy an additional run of 400 of the News Extras, to be distributed to each member of his county medical society. He expressed the opinion that the condensation, prepared by John W. Moses, M.D., Detroit, MSMS Scientific Editor, was excellently done and ought to receive wide distribution. Following are additional examples of the responses to the News Extra.)

To the Editor,

I am hoping that you have an overage of 25 copies of your February, 1970 *Michigan Medicine* newsletter. The members of our Board of Trustees would profit by reading the summary of the Himler Report and the Minority Report. If you do not have extra copies available, we will run our own.

Cordially,
John G. Nolen, D.D.S.
Executive Director
Michigan Dental Association

* * *

To the Editor,

I have studied the official issue on the Himler Report with comments from the Budd Minority Report, and before presenting this to the Medical Society for any action, I feel some comments are necessary.

I would certainly be in broad general agreement with the Himler Report and the Budd Report comments are certainly most pertinent; however, in the publication it is a little hard to really follow what the Budd Report is all about since you make continuous reference to certain pages and paragraphs, and I find nothing of this in the condensed version of the Himler Report.

Certainly I do not feel that anyone can either accept or reject the report on the basis of this publication, which is really a hodge-podge of apparently inter-related but non-related material, and if you have a copy of the Himler Report with the Budd Minority Report in whole, I would certainly appreciate being able to receive a copy, so that the Medical Society would be able to study it and make pertinent comments and recommendations. As this publication stands, I don't feel we can either accept it or reject it.

Very truly yours,
John W. Grigg, M.D.
Secretary-Treasurer
Bay-Arenac-Iosco County Medical Society

Ribicoff's "Medical Malpractice" Challenged

(A copy of the following letter was sent to Sen. Abraham Ribicoff, chairman of the Subcommittee on Executive Reorganization, U.S. Senate, Washington, D.C. MSMS President Robert J. Mason, M.D., Birmingham, after seeing a copy of the letter, recommended it be printed in MICHIGAN MEDICINE. Approval to do so has been given by Doctor Pool.)

To The Editor:

I read the extraordinary document "Medical Malpractice" submitted by your committee. As the President of the Michigan Academy of Plastic Surgery, I am very concerned over the problem of medical malpractice and litigation. I am very disturbed over the plight of any patient that suffers an injury from negligence of a physician and I believe that litigation has a role in protecting the patient in this regard.

There is a very real question, however, whether the legal profession should be given the responsibility they currently have in medical malpractice litigation.

Let us review some facts pertinent to our local area. Eighty-five percent of the cases presented as malpractice by the legal profession in our area are totally unfounded. This is completely in disagreement with your document. Of the other 15 percent who have been given judgments, it is the opinion of attorneys in this area that only five percent are really legitimate. The other 10 percent have been given awards which more correctly could be termed "social awards for physiologic catastro-

(Continued on Page 329)

Remember how great milk of magnesia tasted?

Almost as good as castor oil.

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And Dulcolax works so predictably that the time of bowel movement can often be predicted. Tablets taken at night usually produce a bowel movement the following morning. Suppositories generally work in 15 minutes to an hour.

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A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.

The pain of earache was allegedly relieve
by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.

A realistic approach to pain relief

'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

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phes." These are the sympathy awards where the physician has participated in the care of a patient with an overwhelming problem. Since he is not the Lord he was unable to heal his patient, and the court interprets his failure as malpractice. The case is not really malpractice. The award is not a malpractice verdict but it is called that these days because society has no other form of recompense for this seriously disabled individual.

LET'S TAKE a hard look at the 95 percent of cases of litigation. Why pays for them? The public does. Who is going to pay for the rising premiums? The public will. And who profits from this litigation? In 85 percent of the cases *only* the legal profession gains. In 15 percent the legal profession gains 40 percent of the settlements and the patient may get the rest.

I personally have had threats for malpractice litigation against me by several attorneys. These threats have done three things to me personally. I now must order an extraordinary number of laboratory tests to cover myself and to look good in my charts. This considerably increases the cost of medical care. Secondly, it discourages my participation in emergency care at our local hospitals because this is the primary source of patients who are extremely difficult to manage. This is a very necessary community medical service which every doctor performs. Lastly, it makes me very hesitant to work the long hours I have worked, perhaps no longer than yours, but certainly longer than those of most other professions. I don't begrudge those hours because I like my work, and I am very happy to perform it. However, as I see my legal risk increase, and have diminishing amounts of time with my family the choice becomes more and more difficult. If doctors all over the United States become less productive than they currently are we are going to have an even greater problem with medical care delivery in the United States.

In summary then, what do you get from 95 percent of the medical malpractice litigation today? A very large sum of money for the legal profession, increased medical cost to the patient, and a very powerful force inhibiting the physician's productivity.

IN READING your booklet, Mr. Ribicoff, I feel precisely the way you must when someone damns the entire United States Senate because of one of your colleague's actions. Please tell me, Mr. Ribicoff, why is it that you didn't send your list of questions to physicians and publish their responses?

Let's have vigorous prosecution of legitimate cases of malpractice. But for the cases that have no basis in fact there are some very real unanswered questions. What are the rights of a physician who is incarcerated for an extended period of time on a case which may have no merit at all? What is the difference between that and illegal search and seizure? I see absolutely none. The courts now allow any attorney to do this. I object. And judging by the tone of your document it is my impression that you think it is correct. And with that I completely disagree.

Robert Pool, Jr., M.D.
Birmingham

Psychiatrists' Aid Needed in Programs

To the Editor:

The following questions and comments have been formulated on the basis of my experiences as a physician and child psychiatrist. I am stimulated to respond to the statements and questions by Governor Milliken, published in the February issue of the journal of the Michigan State Medical Society.

First, how many people are aware that hereditary and constitutional factors are probably the most fundamental basis for learning problems, retardation, and mental illness? This probably explains why the success of mental health treatment is still more dependent on careful selection of treatment candidates than on the superiority of a treatment method.

SECOND, HOW MANY PEOPLE are aware that the child's interpretative equipment determines the response to educational stress and directs the amount of tension, fear, rage, or despair that is internalized or acted out? The degree and direction of motivation is probably related to the health of the internal spirit. Have we forgotten how some children learn to numb themselves to the humiliation, ridicule, and hurt that children with impulse control and learning difficulties experience in our academic-achievement oriented schools? Why is so little being done to save a person's self esteem by use of appropriate non-academic facilities beginning in the first grade? How many people are aware that, if the school fails or aggravates the problem, the result may be a mentally disturbed person who may; a) need 1-40 or more years of mental health treatment, b) spend months in jail, c) get killed in some impulsive hedonistic act, d) raise a family on welfare, or e) become an alcoholic?

Third, are you aware that there is increasing agreement that environment is generally less important than heredity — constitutional and interpretative features as a cause for mental disturbance? You probably know good families who have not been deprived of good books in the home,

(Continued on Page 332)

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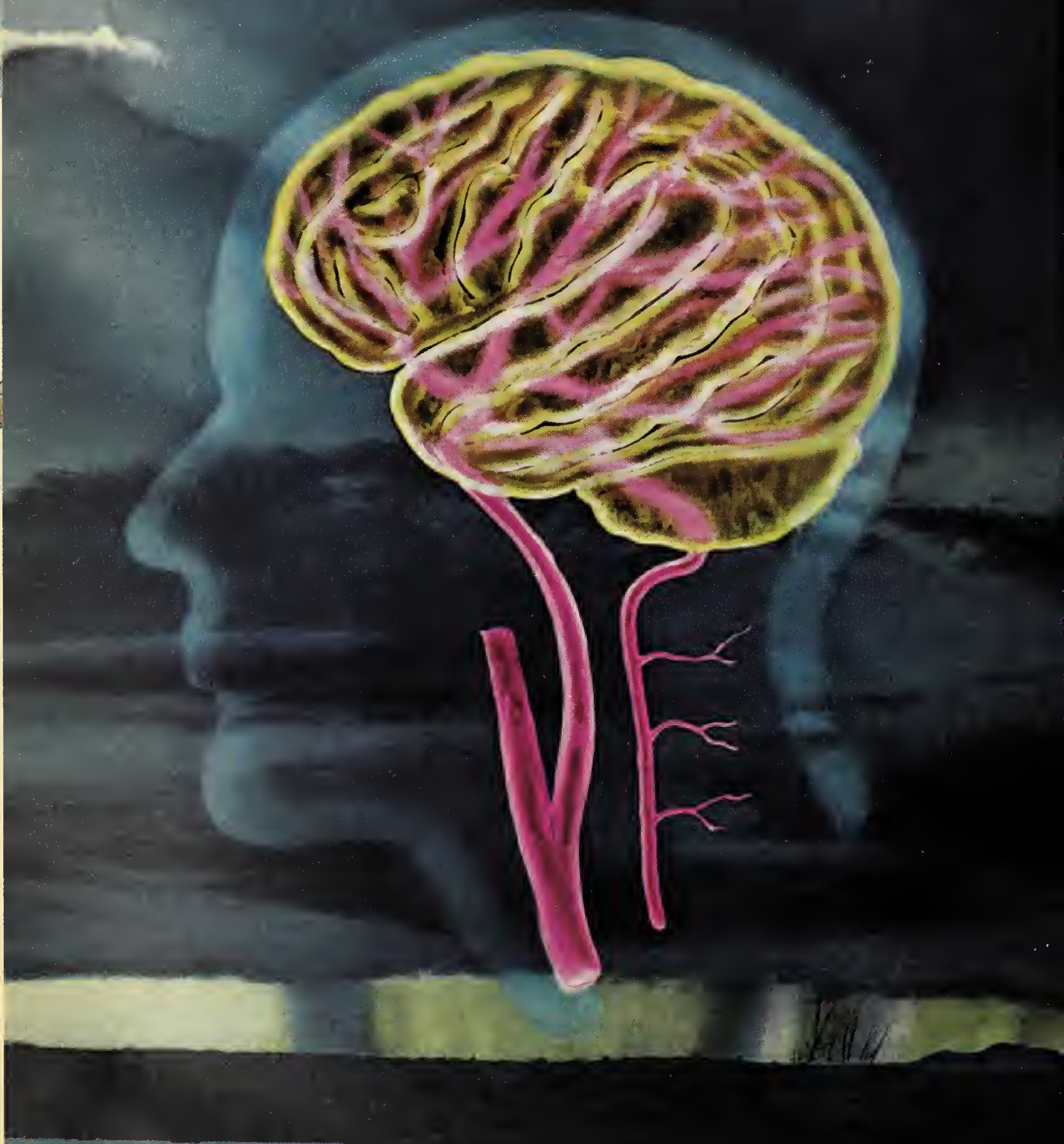
When Cerebrovascular Disturbances occur…



...with episodes of vertigo, headache, confusion, sensory loss, slurred speech, consider

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to help relieve symptoms by preventing vasospasm and increasing cerebral blood flow

New 20 mg. strength now available: Vasodilan 20 mg. tablets for greater dosage simplicity and convenience. Recommended *initial* dose: one 20 mg. tablet q.i.d.

lthough not all clinicians agree on the value of vasodilators in vascular disease,[1] several investigators[2-5] have reported favorably on the effects of soxsuprine on cerebral blood flow. Effects have been demonstrated both by objective measurement[2,5] and observation of clinical improvement.[2-4]

ndications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), aynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **omposition:** VASODĪLAN tablets, isoxsuprine hydrochloride 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications nd Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial leeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 ng. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not ecommended. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Fazekas, . F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: Angiology *15*:No. 2 (Feb.) 1964. (2) Horton, . E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 June) 1960. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *5*:82-87 (Feb.) 1964. © 1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 75970

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LABORATORIES

Humor, Concern Part Of Days' Mail At MSMS Headquarters

"Gentlemen, please send me any information you may have concerning a lavatory technician."

That request arrived in the mail at MSMS Headquarters one day from a young Detroit girl. It was one of the interesting, handwritten pieces of mail that occasionally come mixed with the average day's deluge of news releases, publications, bills, dues and official statements.

Mail to MSMS staffers usually includes requests for AMA booklets and pamphlets, for copies of "The Human Side" television and radio program scripts, and for annual session display space for future exhibitors. Physicians ask about their insurance policies and members of the general public ask for the names of physicians who specialize in particular fields.

But occasionally a note arrives asking that MSMS "forward to me immediately all information that you may have" on a topic as broad as sex education or Medicare. Such a request might draw a groan from the staff member.

A SMILE might be the reaction to the note, "I'm sorry that you could not help me any more than you did. I still thank you very much for doing your best."

An identical response might be rated by the hopeful letter relating that "I am trying to find a profession that is to my liking. I would be very thankful if you could help me with something" — particularly when the writer explains that he is most interested in music "but I am always looking."

Many letters correctly request information on various medical careers or the official stand of MSMS on a medical issue of the day.

One that brought real concern and prompt action from the MSMS office was written on bright pink note paper by a Michigan high school girl.

"I'm really worried about my friends," she began. "Not only are they taking marijuana, LSD and mescaline, but they are inhaling bactine, paint and lacquer. I'd really appreciate some information on what these things are doing to them so I can try to help them. Especially the effects of lacquer seeing that it is so inexpensive they use that the most. Please help in a hurry before they hurt themselves."

AFTER RECEIVING the first collection of information on drug abuse, the same young girl replied, "Thank you very much for the pamphlets on drugs, but could you please try and find some information on inhaling lacquer. It's the newest thing here and more and more kids are doing it. If they knew what they were doing to themselves I'm sure they'd quit."

Obviously, the human element is represented in the mail to and from the state offices of an organization like MSMS.

But the clincher for one MSMS staff member who has been speaking at medical meetings around the state, came when he received a request for his "biological sketch" so that he might be properly introduced to a future audience.

MAILBAG/Continued

good teachers in good schools, good diets, and good medical care and still the children have fallen apart or gone off the deep end.

Therefore, is it wise that mental health and educational funds be spent with so little supervision or involvement with psychiatrists? Is there some more successful way for psychiatrists to offer their experiences and recommendations to community mental health and educational planners? Is it necessary to have the majority of the mental health funds controlled by programs that do not have maximal psychiatric involvement? Many of these programs seem unwilling or unable to work with those individuals most in need.

Some mental health workers have needed to change their practice location because paying patients are taken into public clinics. The end result seems to be less service for those with the greater needs and the least ability to buy services.

In spite of excellent mental health facilities in the Kalamazoo area, the majority of those in need of professional help are unable to get much mental health service.

THE BASIC PROBLEM in the area of community mental health is not the lack of facts — the basic problem is the interpretation of the available data by idealistic environmentalists who have little biological, medical, or psychiatric training and who probably have most of their experience and income from institutional settings.

A society whose compromised operations are hung up on concepts about supranatural phenomena, while attempting to solve modern problems, is likely to become a welfare and police state.

Sincerely,
Lawrence D. Stieglitz, M.D.
Child Psychiatrist
Kalamazoo

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It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.
1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

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(Continued on Page 338)

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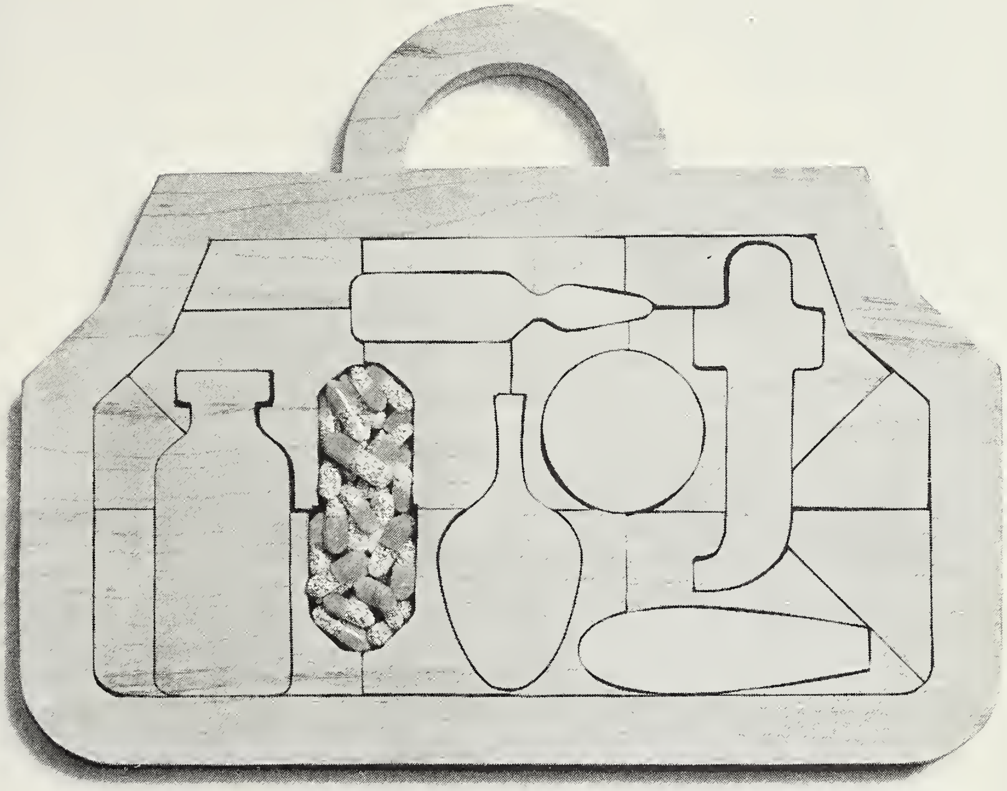

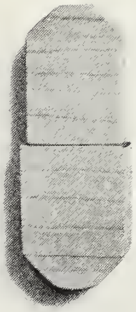

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Health Committee Sends 26 Recommendations To State Education Board

The State Board of Education recently received the final report and 26 major recommendations from its Citizens Committee on Education for Health Care.

Among the recommendations were those to:

Encourage innovative approaches to education of health care personnel.

Develop data bank for health manpower information.

Begin plans for health occupation centers.

Promote programs in medical librarianship.

Improve quality of medical technology education.

Establish single health manpower planning advisory body.

Continue regional health manpower studies and plans.

Begin plans for physical therapist training.

Begin plans for third dental school.

Begin plans for college of optometry.

The state committee earlier had recommended a fourth medical school.

MAGP Annual Postgraduate Clinic June 29-July 1 at Boyne

The Michigan Academy of General Practice will stage its 24th Annual Postgraduate Clinic June 29-July 1 at Boyne Highlands.

The MAGP Congress of Delegates will convene on Sunday, June 28, with the Scientific Program to begin at 9 a.m. Monday, June 29, and end at noon Wednesday, July 1. The three-day program will consist of individual papers, panel presentations and a clinic on fractures. In addition, 60 scientific and technical exhibits will supplement the formal program.

Special speakers will discuss Drug Abuse, Professional Corporations and Abortion and Contraception.

Out-of-state speakers for the three-day program will include C. Peter Schumacher, M.D., of the Department of Endocrinology, Cleveland Clinic, who will discuss "Juvenile Diabetes—Acute and Long-term Treatment"; Penn G. Skillern, M.D., head of the Department of Endocrinology, Cleveland Clinic, "Insulin in Management of Adult Diabetes"; Ray W. Gifford, Jr., M.D., head, Department of Hypertension and Renal Disease, Cleveland Clinic, "Recognition and Management of Hypertension"; Richard T. Smith, M.D., Benjamin Franklin Clinic, Philadelphia, Pa., "Rheumatoid Spondelitis," and Seymour Diamond, M.D., Department of Psychiatry, Chicago Medical School, "Pressures of Private Practice."

Participants in the Clinic of Fractures will be Arthur A. Michele, M.D., professor and chairman, Department of Orthopedic Surgery, New York Medical College; Theodore Himmelstein, M.D., associate professor, New York Medical College, and Howard S. Cameron, M.D., professor of orthopedic surgery of London, Ontario.

SEVEN MICHIGAN physicians are on the board of the 1½-year-old American College of Emergency Physicians, which met in Denver recently in its first General Assembly. The seven include, from left in front, John A. Rupke, M.D., Jackson; John G. Wiegenstein, M.D., Lansing, chairman, and John T. Rogers, M.D., Livonia, treasurer. In back are Eugene C. Nakfoor, M.D., Lansing, second from left, and Robert J. Rathburn, M.D., Flint, far right. Missing are John H. van de Leuv, M.D., Oxford, and George C. Fink, M.D., Ann Arbor.

MHA Heart Days And Scientific Sessions May 7-9 in Cobo Hall

The Annual Heart Days and Scientific Sessions of the Michigan Heart Association have been increased to three days this year. They will be held May 7-9 in Cobo Hall, Detroit, with headquarters in the nearby Pontchartrain Hotel.

The first program, at 1 P.M., Thursday, May 7, will be a symposium on "There is Something New in Stroke." Nine specialists will each talk 20 minutes on subject ranging from, "Stroke is a Community Problem," to "Long Term Medical Care." Joseph N. Schaeffer, M.D., director, Rehabilitation Center, Detroit, will be the dinner speaker.

On Friday, the Scientific Sessions will turn to "Cardiology and Surgery — More Hope in the Seventies." The faculty of 19 M.D.'s will include, William T. Mustard, Canadian surgeon who will deliver the annual Wilson-Meyers Lecture; Donald R. Kahn, M.D., heart transplant surgeon, U. of M.; Harvey G. Kemp, director of Laboratories, CVD Unit, Peter B. Brigham Hospital, Boston; G. C. Rastelli, surgeon, Mayo Clinic; Herbert E. Sloan, Surgeon, U. of M., and Park W. Willis, III, director, Heart Station, U. of M.

Friday's sessions will each be climaxed by "Surgical Treatment" discussions on "Congenital Heart Disease," at 11 A.M., and on "Coronary Heart Disease," at 4 P.M.

Saturday's session will highlight a discussion of The Status of Heart Transplantation" by Doctor Kahn. It will close with an informal luncheon at which speakers will be available for discussion.

At the Sixth Annual Cardiovascular Nursing Session, scheduled for all day Friday, May 8, E. Walton Lillehei, M.D., nationally known surgeon, will talk about Cardiogenic Shock, and Nanette Kass Wenger, M.D., associate professor of Cardiology at Emory University, Atlanta, will discuss "Congestive Heart Failure."

In the afternoon there will be four separate nursing sessions: "Electrocardiograms from P to T"; "Pacemaker Patient in Daily Life"; "New Perspectives of Vascular Surgery," and "Psychological Aspects of CVD Disease." The latter will feature a talk from the patient's point of view.

Friday morning there will be a special session on ECG operation for technicians, as well as a special Cardiopulmonary Resuscitation program, which will deal with emergency handling of heart attack victims. At noon, there will be an Annual Luncheon and meeting of Association members and in the afternoon, a free public forum at the Northland Theater, in Southfield. On Saturday morning, there will be a Heart Association Delegate Assembly.

For Information and/or Pre-registration forms, write or call "Heart Days," Michigan Heart Association, 13100 Puritan, Detroit 48227, (313) 342-2100.

State Hospital Week May 10-16 to Focus On Youth, Careers

Michigan's nearly 300 hospitals will begin observance of Michigan Hospital Week, Sunday, May 10th. The special week is again promoted by the Michigan Hospital Association.

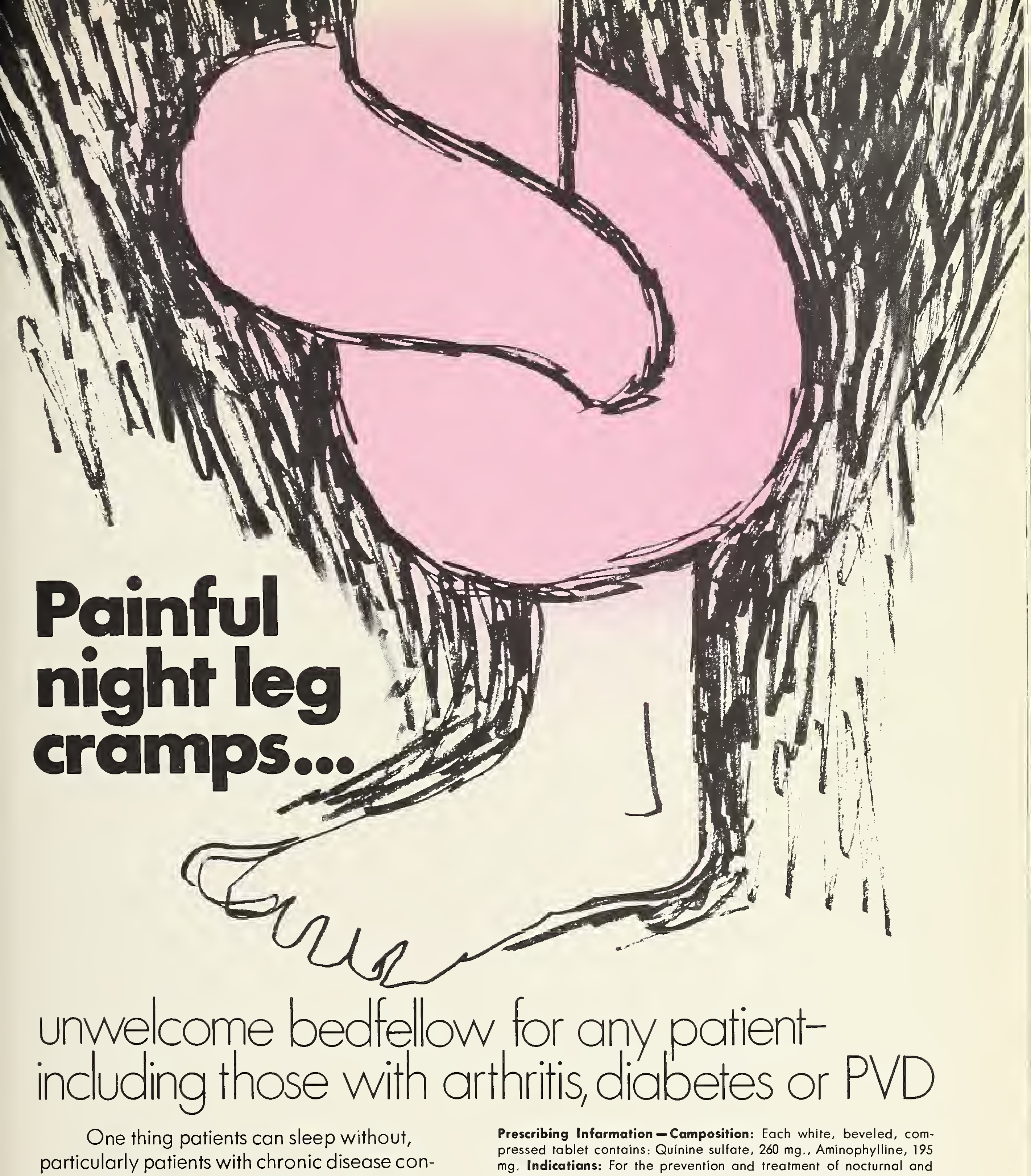
The major purpose of Hospital Week, officially proclaimed May 10-16 by Governor William G. Milliken, is to interest the youth of Michigan in the dozens of career opportunities offered by their community hospitals.

Spear-heading the state-wide educational campaign to help solve the serious personnel shortages confronting hospitals are more than 25,000 women representing the hospital auxiliaries and many other civic organizations.

Schools, churches, businesses, city officials, press, radio and television in cities and towns throughout Michigan will be bringing the story of the hospital and its career opportunities to millions of citizens during hospital week.

Charles G. Skinner, administrator of W. A. Foote Memorial Hospital, Jackson, and president of the Michigan Hospital Association, said Michigan's hospitals have immediate job openings for more than 1,000 persons. Present hospital facilities, he pointed out, will require another 2,500 trained hospital workers within the next five years. New hospital expansion plans, some of which are already under construction, will create more and more jobs.

High schools in many Michigan cities have made special arrangements for students interested in hospital careers to take specially planned tours of community hospitals during the week.



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unwelcome bedfellow for any patient—including those with arthritis, diabetes or PVD

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Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Contraindications: Known sensitivity to sulfonamides; diagnosis or familial history of carcinoma of the genital tract or breasts; precarcinomatous lesions of the vagina or vulva; palpable uterine fibromyoma; mammary fibroadenoma; depressed liver function.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity or sensitivity are reasons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for careful diagnostic measures to eliminate the possibility of neoplasia of the vulva or vagina. Manifestations of excessive estrogenic stimulation through dienestrol absorption may occur. These include uterine bleeding, breast tenderness, exacerbation of menstrual irregularity and provocation of serious bleeding in women sterilized because of endometriosis. Endometrial withdrawal bleeding may occur if use is suddenly discontinued.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: 'AVC/Dienestrol Cream'—Four ounce tube *with* applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 *with* applicator.

References: (1) Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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Cream (dienestrol .01%, sulfanilamide 15.0%, aminacrine hydrochloride 0.2%, allantoin 2.0%)
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Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm acht ck a large rock

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Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

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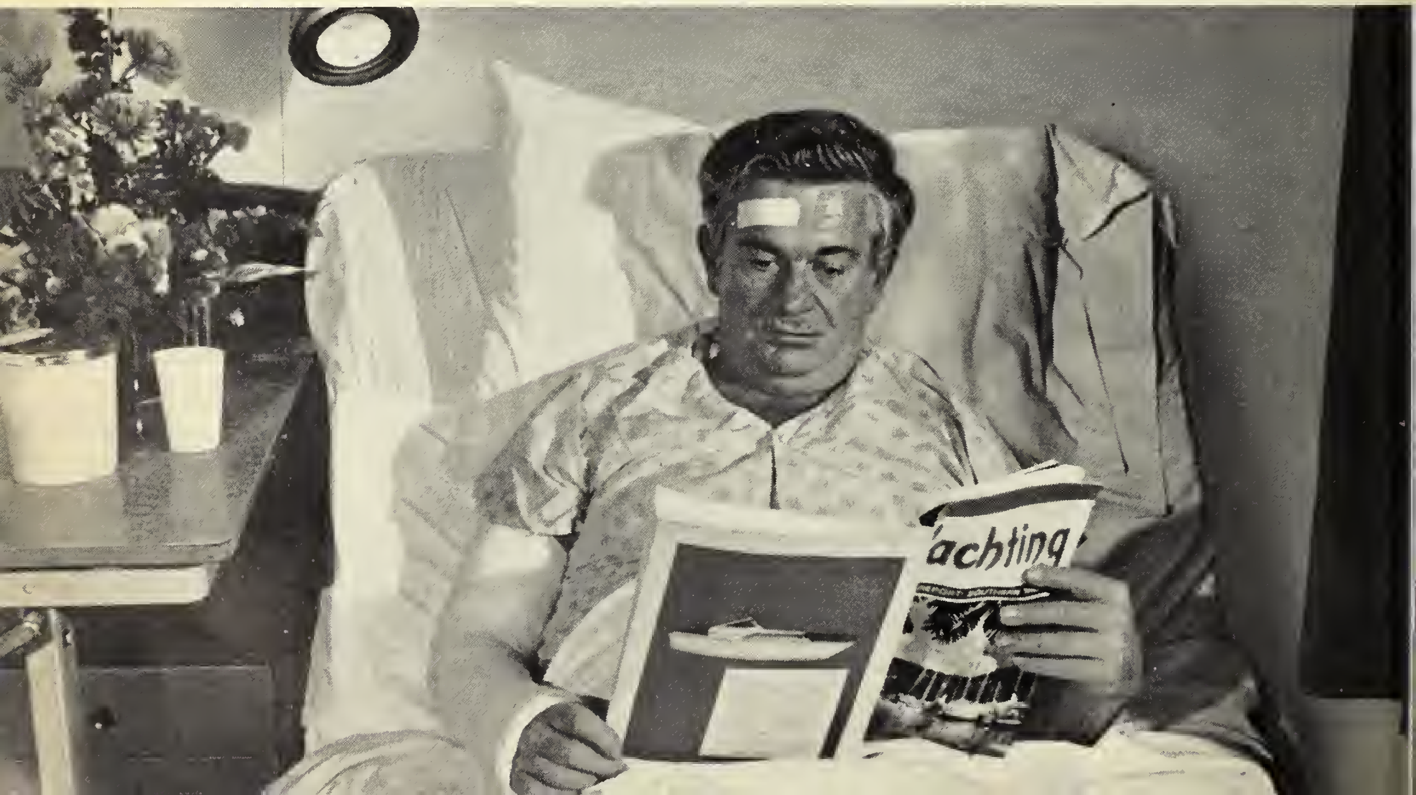
Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



medical care programs

Governor Asks Slight Increase In Mental Health Budget

BY HERBERT MEHLER
STAFF ASSISTANT
MSMS COMMITTEE ON
GOVERNMENTAL-MEDICAL PROGRAMS

IN MICHIGAN

Mental Health:

Governor Milliken's proposed budget to the Legislature calls for modest increases but is not as much as the Department of Mental Health said it needed. He requested $185 million to operate existing facilities for the mentally ill and mentally retarded and nearly $9 million for new facility construction. Although there was some trimming in operating and construction funds, the Department would receive a net gain, if approved by the Legislature, which will upgrade the level of treatment offered in state and community mental health services. One of the new programs recommended was a $1 million community mental health center and $680,000 (½ federal) drug Marine Hospital. The budget request also included:

An increase of $500,000 to improve existing community mental health services.

$1.35 million beyond current levels to upgrade the level of care in homes for the retarded.

$813,000 above current levels to improve services for the mentally ill.

$600,000 to improve data processing and other management tools in the Department's central administration.

$3 million in planning construction money to build new facilities for the mentally retarded now crowded at the Fort Custer State Home by phasing out this Home and building four regional mental retardation centers of 500 to 700 beds each to care for children. Two of these homes would be in Wayne County, one in Clinton Township to serve Macomb and a part of Oakland County and the fourth would serve the Kalamazoo region.

Detroit Comprehensive Health Services:

The Governor approved an Economic Opportunity grant of $1,631,753 to the Detroit-Mayor's Committee for Human Resources Development for a Comprehensive Health Service. It is anticipated that the program will reach some 15,000 poor in Detroit target areas. This program, run on a family basis, will provide preventative, curative and rehabilitative health care covering a wide range of medical services.

* * *

Executive Order 1970-1 issued on January 15, 1970 rescinded Executive Order 1967-7 and created the State Comprehensive Health Planning Commission and the Office of Comprehensive Health Planning to be located in the Executive Office. The 1970-1 Order reduces representation of the State Commission to six members to include the Directors of the Departments of Public Health, Mental Health, Social Services, Labor and Education and the Chairman of the Comprehensive State Health Planning Advisory Council. The Order delineates the responsibilities and functions of the Commission, the Office and Advisory Council. This Order also included an MSMS recommendation for an appeal procedure which will now allow "any public or private agency, organization or facility aggrieved by the action of an areawide Comprehensive Health Planning Agency or by the action of the state and having exhausted local procedures may request a hearing before the Advisory Council on Comprehensive Health Planning."

* * *

IN WASHINGTON

Merging of Regional Medical Programs and Comprehensive Health Planning?

The Health Services Improvement Act of 1970 (S. 3443) was introduced in Congress to combine Comprehensive Health Planning and Public Health Services Programs and Regional Medical Programs under the U.S. Public Health Service Administration. Also included, if passed, would be the National Center for Health Services, Research and Development, an intra-HEW agency. If this legislation passes this would mean that MARMP (Michigan Association for Regional Medical Programs) and Comprehensive Health Planning would unite under a common statement of purpose, a single national advisory council and a single annual report on their "progress toward a health care system." The bill calls for intensive experiments and demonstrations in selected states, regions and localities for the purpose of stimulating the development of health care systems which might be used elsewhere in the nation and also provides new authority to the Public Health Service for the development of a federal-state-local system of health information and statistics.

At the same time that the merger of RMP and CHP is being proposed (above) H.R. 15895, the Comprehensive Health Planning and Services Act of 1970 was introduced. The bill authorizes $787.5 million for fiscal 1971, 72 and 73 to continue grants to states for comprehensive state health planning project grants for areawide health planning, grant programs for comprehensive public health services and project grants for health services development.

New Observations of Inner-City Health Care Revealed In WSU Continuing Education Plan

Some observations and statistics about health care in the Detroit inner city are presented in a Wayne State University School of Medicine proposal to MARMP for "An Experimental Continuing Education Program for small inner city hospitals."

The WSU proposal, still under review by MARMP, would "improve patient care provided by private physicians in small inner city hospitals. the WSU proposal, in part, says "Abundant evidence suggests that the diagnostic, treatment and patient management skills of these physicians in solo or single specialty group practice who are limited to staff privileges in small hospitals deteriorate over time."

THE WSU PROPOSAL offers these comments about inner city health needs:

"Recent studies have clearly documented that inner city populations across the country suffer higher mortality rates and a much higher incidence of cancer, stroke, heart and related diseases than their outer city and suburban counterparts.

"In the Model Neighborhood of Detroit (a local poverty area slated for multiple federal assistance programs), deaths from heart disease, cancer, and vascular disease rank as the major killers.

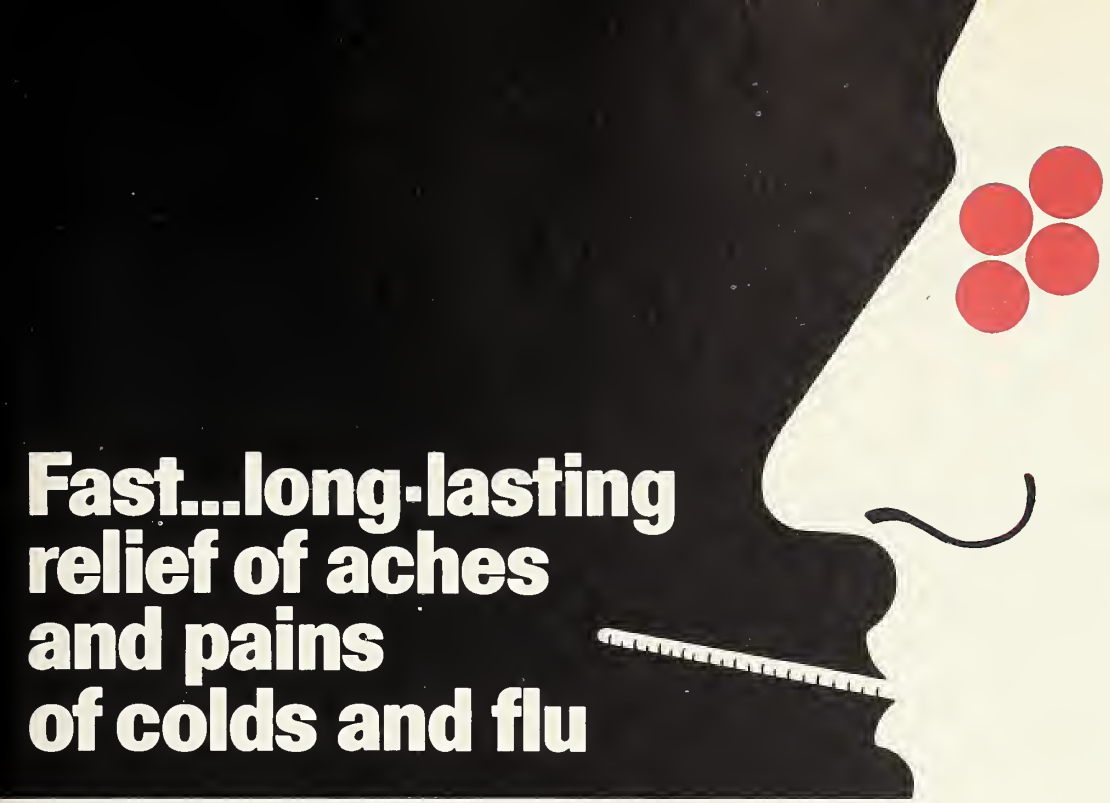
"The gap between science and practice to which P189-239 addressed itself, is nowhere more observable than in the congested inner cities. For the hard-core unemployed, indigent populations in these areas, the 'best in medical care' ideally may be brought within reach through the public sector of medicine by way of governmental assistance programs; however, such programs are often dehumanizing, inaccessible, disjointed and fragmented and hence are avoided, wherever possible, by the poor.

"For the indigent, the employed poor, and retired elderly populations locked into the poverty culture of these areas, the best in medical and full facility hospital care may be financially accessible through the private sector by means of third-party payments. However, available and accessible medical care for this population tends to be that delivered through groups whose offices are still in or directly adjacent to the lower income neighborhoods, whose office hours are more structured to accommodate the working of personalized care.

"In the Model Neighborhood area of Detroit, for example, 56% of the population is classified as being at the poverty level ($3,000 and under). In 1967, 70% of the population fell below the mean family income ($7,500) established for the country as a whole in 1960.

"However, 71% of this same population reported having a third party payor either through private insurance or Title XVIII and XIX, and 67% reported having a private physician and local hospital, other than Detroit General Hospital, to which they went for their medical care.

"This reliance of the poor on private practitioners related to small general hospitals is further demonstrated when the 1966 patient Origin Study of the Greater Detroit Area Hospital Council is examined in terms of the census population characteristics of the areas from which hospitals drew their greatest percentage of their patients from areas which were significantly lower on such socioeconomic characteristics as education, income, employment and housing than the areas from which the larger community hospitals drew their largest percentage of patients."



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May 13

RECENT ADVANCES IN MEDICINE

Room I	***Room II***	***Room III***
SURGERY 9:00 - 11:30 a.m.	**GYN - OB** 9:00 - 10:30 a.m.	**NEUROLOGY** 9:00 - 10:15 a.m.
	PATHOLOGY 10:30 - 11:30 a.m.	**ORTHOPEDICS** 10:30 - 11:30 a.m.

MEDICAL ALUMNI — *School of Medicine Luncheon*

MEDICINE 2:30 - 5:00 p.m.	**ONCOLOGY** 2:30 - 3:50 p.m.	**OPHTHALMOLOGY** 2:30 - 3:50 p.m.
	ANESTHESIOLOGY 4:10 - 5:00 p.m.	**OPTHALMOLOGY** 4:10 - 5:00 p.m.

6:00 p.m. Reception
7:00 p.m. BANQUET — Cobo Hall Ballroom, overlooking Detroit River

May 14

MORNING SESSION *The Future of Medical Practice*

SOLO PRACTICE: Michael Halberstam, M.D. (Washington D.C.)
GROUP PRACTICE: Leonard Lovshin, M.D. (Cleveland Clinic)
GROUP PREPAID: Wallace Cook, M.D. (Permanente Foundation, Walnut Creek, Cal.)

PARKE-DAVIS LUNCHEON

AFTERNOON SESSION *The Government's Role in Providing Medical Care*

SPEAKERS: Roger Egeberg, M.D., assistant secretary of Health, Education, and Welfare (or his representative)
Jerome Pollack, M.D., Harvard Medical School associate dean for medical care planning

DISCUSSANTS: Doctors Halberstam, Lovshin, and Cook

EVENING SESSION *Wayne State Alumni Class Reunions*

EDICAL ALUMNI

3-14 at Cobo Hall

Advance Registration

for the Clinic Days and the May 13 evening banquet can be made by writing: Alumni House, Wayne State University, Detroit, 48202. There is a charge of $30 per couple for doctors and $15 per couple for residents for the banquet.

medicolegal

(Editor's Note: The following articles are quoted from the AMA CITATION newsletter of Dec. 1, 1969, prepared by the AMA Law Department.)

Disputed Evidence of Psittacosis

In a personal injury action by the buyers of a parakeet who contracted psittacosis, commonly called "parrot fever," the Supreme Court of Michigan reversed summary judgment in favor of the seller and remanded the case to the trial court for trial, ruling that there were disputed questions of fact as to whether they contracted psittacosis.

The court stated that the examination of the pleadings and depositions, including those of medical experts, disclosed that there was a material question of fact as to whether the buyers had contracted psittacosis or had contracted pneumonia. The court pointed out that summary judgment will not lie where material facts are at issue.

The depositions of two doctors stated that the patient's spleen was enlarged, which does not normally occur in pneumonia cases, but is a symptom of psittacosis. However, the two doctors also stated that the failure of the rise in titer of the psittacosis complement-fixation test and the negative results in the sputum culture test made it impossible to make a specific etiologic diagnosis. They also stated that psittacosis is a form of pneumonia and that it is often difficult to distinguish between the two.

A third doctor stated that he had read the hospital records and that, although he was of the opinion that there was a rise and fall in titer in the results of the complement-fixation test, he could not state with a reasonable degree of medical certainty that the patient had psittacosis, because he had not seen the patient, only the hospital records.

Based upon this testimony and upon lay testimony concerning the prevalence of psittacine birds in the area at that time, the court concluded that there existed a material question of fact upon which reasonable minds might differ. It therefore remanded the case for trial.—*Bilicki* v. *W. T. Grant Company,* 170 N.W. 2d 30 (Mich., Sept. 3, 1969) *from Vol. 20, No. 4*

DUTIES OF HOSPITALS IN TREATING EMERGENCIES

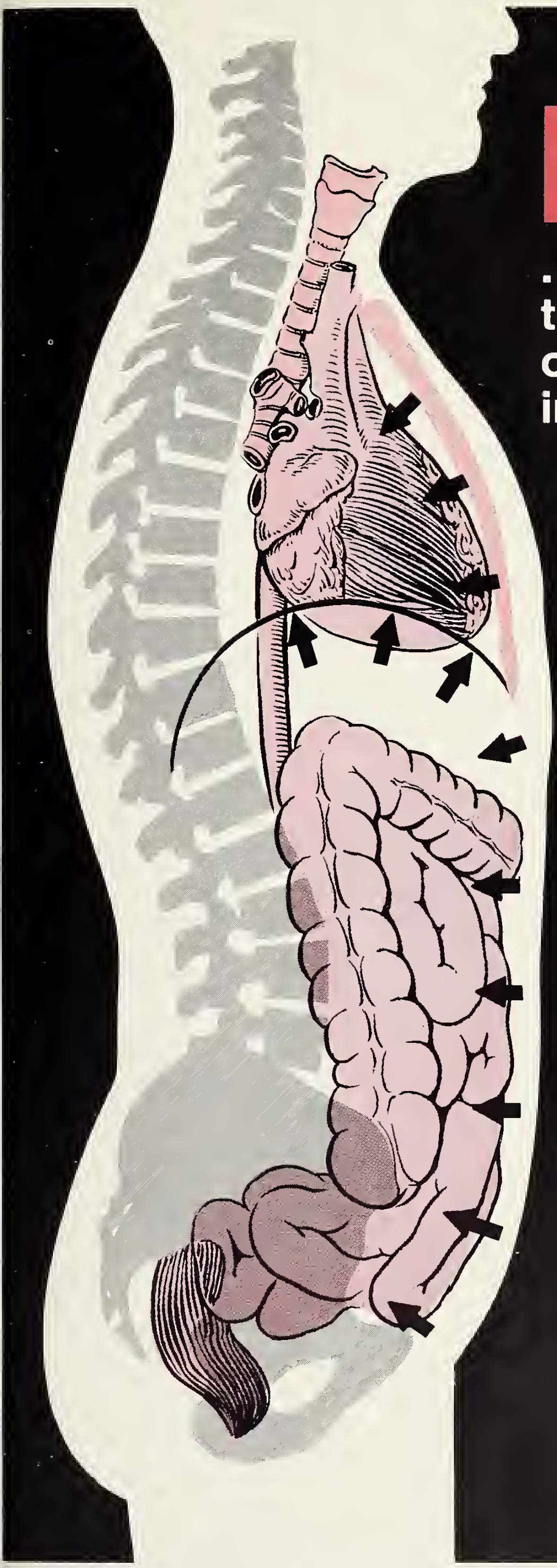
The hospital emergency room has become a place to treat all types of injuries and ailments, the author of a law review article notes. Its role has been greatly expanded, due to the disappearance of house calls by family doctors and to the advent of the modern clinic with regular hours for doctors. With an increased expansion of the role of the hospital emergency room, the question has arisen as to the legal obligation of the hospital to treat patients in an emergency situation.

The traditional common-law rule is that there is no duty to render emergency care to another who is in peril. As a result, in the absence of statute, hospitals may justifiably refuse to render emergency care to a person who is in need of immediate treatment. However, certain exceptions to the common-law rule exist, which will impose a legal duty upon the hospital to render aid. First, if the act of an individual places another in peril, there is a duty to come to the aid of the endangered person, even though the force which threatened peril was innocently set in motion. Secondly, where one person sought to confer a benefit upon another and the second person suffered harm because of reliance upon the supposed benefit, the law imposes a duty to aid. Finally, where the parties are in a special relationship whereby there is a dependence of one upon the other, there is a duty to aid the one in peril.

The common-law rule, with its concommitant exceptions, has resulted in confusion as to just when emergency treatment must be rendered. This confusion is compounded by the fact that, whereas the general feeling of society is that emergency treatment should be required in all cases, the law has not developed from its common-law origins to the point of creating a legal duty upon hospitals to render aid in all cases.

In an effort to frame the law in a context whereby it would set standards concurrent with the feeling of the community, the courts have manipulated the common-law rule to establish a duty to act and to render treatment even in a situation supposedly within the protection of the common-law general rule. In these cases, the courts have focused on any fact which could reasonably be interpreted to make a finding that the hospital had exercised some control and, as a result, was placed under a duty to render complete aid to the imperiled patient. Thus, where the hospital gave some aid and then released the patient in a condition no better than before treatment, or gave the patient reason to believe that the emergency had passed, the courts have imposed liability. In addition, the courts have fastened liability even where the hospital gave no aid but had kept the patient for a period of time, thus

(Continued on Page 352)



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*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice*, 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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precluding him from receiving treatment elsewhere. Finally, the most patent example of manipulating the common-law rule has been the requirement in some jurisdictions that if there is a true emergency, the hospital must minister aid to the patient. These examples indicate that in hospital emergency situations there are no adequately formulated legal standards. Consequently, hospitals must be extremely cautious both in how they act and in how they fail to act.

In conclusion, it may be said that the desirable approach would be to have specific legal standards outlined in order that all persons may know what duties are imposed on them. This would require an abolition of the common-law rule and a formulation of standards in conjunction with the generally accepted conception of the role of the modern hospital. The fact that both the public and the medical profession feel that hospitals should provide aid to those in need goes far in arguing for the imposition of a legal duty on hospitals to grant emergency aid in all cases. — "Hospital Emergency Service and the Open Door," by Leonard S. Powers, *Michigan Law Review*, Vol. 66, No. 7, p. 1455, May, 1968 *from Vol. 20, No. 4*

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(Editor's Note: The following article is quoted from the AMA Citation newsletter of Dec. 15, 1969, prepared by the AMA Law Department.)

Election of Hospital Trustees Upheld

The election by the County Board of Supervisors of the members of the board of trustees of a county hospital was valid, even though the hospital was not yet physically established, a Michigan appellate court ruled.

The establishment of a county hospital was approved in an election by the votes of the county. The hospital has not yet been physically established. However, the Board of County Supervisors appointed trustees for the hospital board and provided for election, by the Board of County Supervisors, of successors to such trustees.

The taxpayer bringing this suit contended that the County Board did not have the authority to elect hospital trustees until the hospital was physically established.

A statute provides that the County Board shall appoint hospital trustees after the voters have approved the establishment of a county hospital. The statute then provides for the election of successor trustees at the regular November elections by the voters of the county. The statute further

(Continued on Page 354)

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provides that the Board of any county where a county public hospital is established has the option of providing for the election of hospital trustees by the County Board, instead of by the voters at the November elections.

The court said that it was convinced, from a reading of the statute as a whole, that the legislature used the term "established" in a legal sense. "To establish" means to found, to institute, to originate, and to secure the permanent existence of. — *Martinson* v. *Kreski,* 170 N.W.2d 257 (Mich., June 24, 1969)

from Vol. 20, No. 5

(*Editor's Note: The following article is quoted from the AMA Citation Newsletter of Jan. 15, 1970, prepared by the AMA Law Department.*)

Parents of Retarded Child Need Not Reimburse State

The constitutionality of a state statute was presented to an appellate court in Michigan in a suit brought by the parents of a mentally retarded child. The court decided that the statute was in fact unconstitutional since it was arbitrarily drawn and therefore operated unequally upon those subjected to the statute.

The statute was challenged by parents whose child had been committed to a state hospital for the mentally retarded. Under the challenged statute, the parents were required to reimburse the state for expenses incurred in the care of their child based upon their financial ability to do so. The "net taxable income," shown by their federal income tax return was the standard upon which the ability to pay was based.

The court reasoned that, since the federal income tax laws contained several loopholes whereby certain classes of actual income of a taxpayer are exempted from taxation, basing the ability to pay upon the standard of "net taxable income" permits those of greater financial ability to reimburse the state less than others of lesser financial ability.

The court held that this statute was in violation of both the state and federal constitutions, and therefore ruled in favor of the parents of the mentally retarded child. — *Miller* v. *State of Michigan, Department of Revenue,* 171 N.W.2d 3 (Mich., June 26, 1969)

from Vol. 20, No. 7

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A Response To the Himler-Budd Report

BY RALPH H. PINO, M.D.
FARMINGTON

It seems obvious that the over-all purpose of the Himler Report is to provide to the people of the United States the best possible medical care based on as careful planning as we have the experience and ability to carry out.

Whatever plans the medical profession collectively may work out we are likely to meet with criticism from groups outside and inside the profession. Adequate time for study, and possibly for State Society and A.M.A. public hearings might be helpful before conclusions are reached by the House of Delegates. A new improved and more comprehensive program than we now have could result. What important institution in these times is not studying to improve its status?

A few years ago, the Governor of Michigan set up a Committee of over 50 persons from Michigan to make a study of our higher educational facilities, including those of the health professions. The purposes of that large committee were not very unlike what the A.M.A. is now calling for. A new constitution for Michigan was in the making, and Governor Romney was hoping to set up a model constitution that other states might follow.

HIGHER EDUCATION as required of his committee was to include studies of the medical and associated health professions. A sub-committee was named to work out ways and means to provide comprehensive health care to the less privileged, but aiming to leave the adequately privileged in the hands of private enterprise. In general the overall committee was non-partisan in membership and made up of some of wealthy and others of moderate and lesser circumstances. For about two and one-half years this Committee met on an average of every two weeks with subcommittees reporting on special problems to the overall committee.

Now to isolate a part of the basic consideration of the health care educational report of the Governor's Committee that might provide some useful information if applied to the analysis of the Himler and Budd material:

"Several years ago there began the building of county and community hospitals to bring hospital care closer to the people and to attract physicians and nurses into the areas. This helped, but it was soon found that single counties could not afford to build a hospital large enough nor well enough equipped to be satisfactory. So as one feasible suggestion, consideration was given to the possibility of locating new Community Hospitals as close as possible together where three or four counties converged, to secure better facilities and so to draw more doctors, including specialists, closer to the hospital facility. Under such an arrangement, costs would be spread and health care increased.

"To arrange for emergencies and to provide transportation for whatever medical service undertaken, the amount saved by building one hospital instead of three or four would make it feasible to provide some buses and some ambulances for transportation of people from the area for hospital, or out-patient, or private care. Such planning could reduce the need for counties to compete with each other, and the transportation facilities would cost very little as compared with the cost of one instead of three or four hospitals.

"GOVERNOR ROMNEY was particularly concerned not only with expanded services of all kinds, but of so organizing them as to cut the costs as far as possible, and so the subcommittee report on health care fitted into that framework.

"It is of interest that in 1965 the Department of Economics of the Division of Socio-Economic Activities of the American Medical Association put out a brochure of 164 pages on *The Distribution of Physicians in the United States by State, Region, District, and County, 1965*. The information dates from April 6, 1964, and gives data such as the following:

"On the above date the total number of physicians in the United States was 277,366. Of this number 21,479 were in the federal services; 1,752 were practicing in the United States Possessions, and 1,773 were listed as temporarily foreign, and 1,134 as address unknown. 70% of these physicians, or 174,685 were in private practice; 61% specialists, and the remaining 67,499 were listed as general practitioners.

Such data is broken down for each state and each county in each state, and regional larger cities or medical centers. Similar information is given on hospitals throughout the United States, and likewise the resident population in each area with per capita income and household income, and pages more of important information. Possibly the brochure is familiar to most physicians. I do

(Continued on Page 358)

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Hynson, Westcott and Dunnings 281
Ingram, G. A. Company 363
Lederle Laboratories 282
Lilly, Eli and Co. 292
Mallard, Inc. 319, 320
Mead-Johnson, Inc. 330, 331, 364, 365
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Plainwell Sanitarium 356
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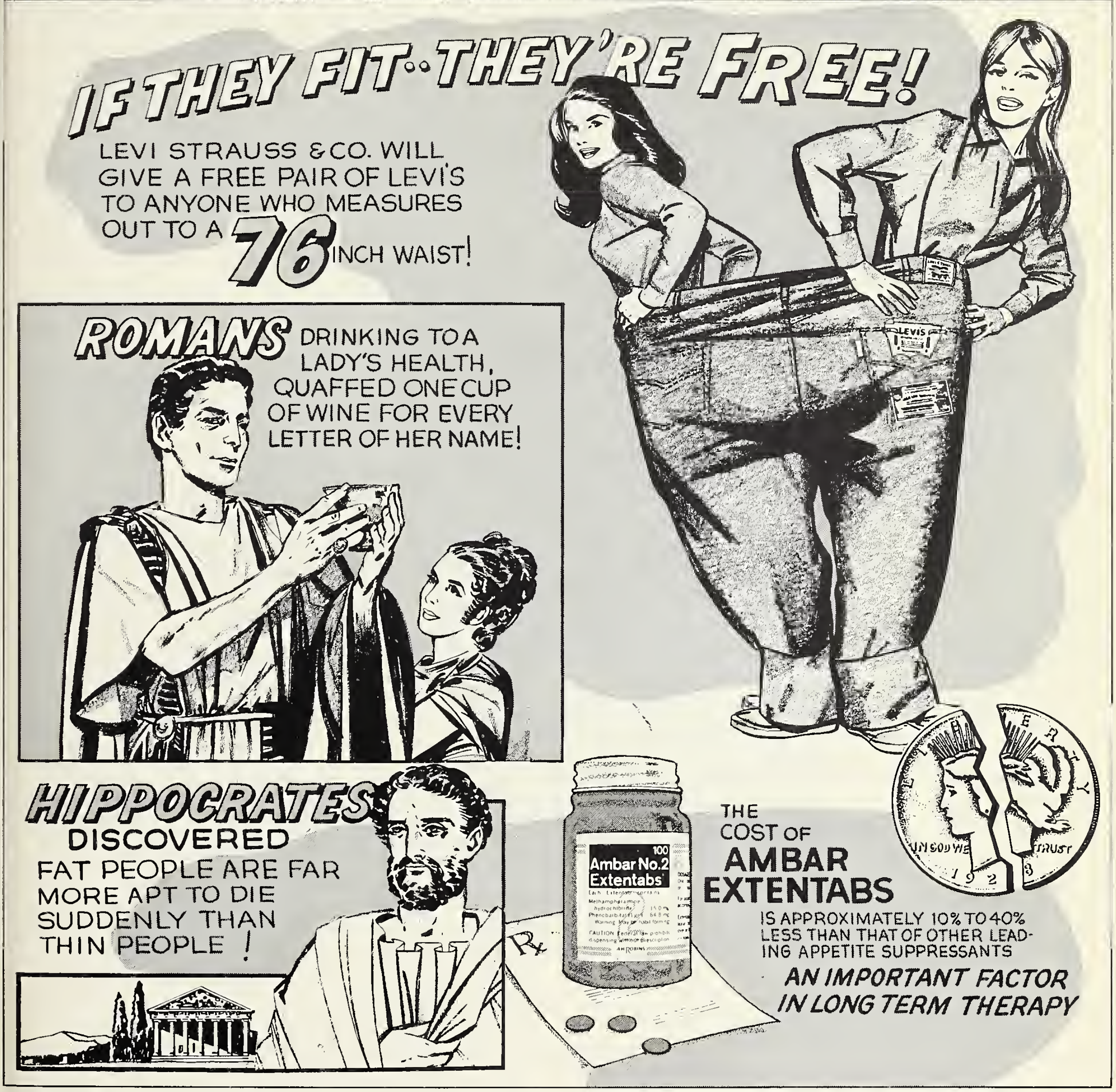

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not know whether it has been brought up to date or not, but I don't see how the committees concerned relating to the Himler and Budd Reports, and the State and A.M.A. Delegates can arrive at adequate conclusions without the use of such data, along with all new incoming data.

AMERICAN MEDICINE may be vulnerable in many spots, but what institution with as heavy responsibilities today is not. A review of our effectiveness over the past 50 years speaks for itself. It is on record. The very nature of scientific medicine is never satisfied.

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(The AMA has extra copies of the 1965 Brochure referred to, which can be obtained at $3 per copy. New editions including 1968 and 1969 will be available by May 1.)

Michigan Doctors' AMA-ERF Contributions Never More Important

BY MRS. DEAN P. CARRON
MICHIGAN AMA-ERF CHAIRMAN
MSMS WOMAN'S AUXILIARY

Dear Doctor,

Thank you for your annual contribution to the American Medical Association Education and Research Foundation. I am the new state chairman for AMA-ERF for your Woman's Auxiliary to the Michigan State Medical Society. If you mailed your contribution to Mrs. Fleming Barbour (for economy's sake the old envelopes were used), do not worry for she has sent it on to me. With rising costs and pressure on the medical schools to graduate more medical doctors, your support of AMA-ERF never has been more important. Of course you know that this contribution is deductible for federal income tax purposes.

AMA-ERF funds collected by auxiliaries support three areas:

(1) MEDICAL SCHOOLS

You may designate your favorite medical school in the United States or Canada. Undesignated funds to medical schools are divided among the 102 medical schools in the United States. Once a year "Medical Schools" money is given to the deans to use at their discretion, perhaps for a special piece of equipment or a fine lecturer not covered by their budget . . . . or to meet the needs of rising costs.

(2) STUDENT LOAN FUND

Since Federal Government money is less available and costs have risen, it was necessary to reppen the Student Loan Fund. AMA had hoped this would be a self-sufficient revolving fund by 1970. In September 1969, over 800 loans were granted. Over 19,000 loans are outstanding now involving some $40 million dollars.

The medical student or doctor-in-training borrows the money he needs from a bank at 7½% interest. Seven national banks participate in the program. AMA-ERF guarantees that the loan will be repaid. If a young doctor meets an untimely death while serving in the armed forces, AMA-ERF repays his loan. For every dollar you contribute, $12.50 are available for loan. Some of our members have considered it unfair to charge 7½% interest. We must remember that bank prime rates are 8% to 9½% and this loan is given to a person without security. . . . . .

(3) BIOMEDICAL RESEARCH

AMA-ERF contributions had helped support the Biomedical Research Laboratories in the AMA Building in Chicago, but at the AMA Clinical Convention in Denver in December, the AMA House of Delegates resolved that the laboratories be closed due to insufficient funds.

County Medical Auxiliaries have many ways to raise funds for AMA-ERF. The ladies have things to sell such as note paper and memo pads supplied by AMA, so profit is 100%. Perhaps you use the memo pads in your office. Medical wives in your county may sell many things such as toys, playing cards, golf balls, Christmas cards and stationery. They have attractive cards for memorial contributions and cards that say, "In Honor," "Thinking of You" and "In Appreciation of." Last year Michigan Auxiliaries raised $22,451.22. We were second to Ohio ($40,701.77) in th North Central region of 12 states. You may giv your contribution to your county chairman or send it to me. Make it out:

AMA-ERF Auxiliary Fund

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RESIDENCY TRAINING IN NEUROLOGY: The Department of Neurology, Wayne State University, Detroit, Michigan has a limited number of positions available for first year residents in the program beginning July 1, 1970 and July 1, 1971. This is a fully accredited program with high standards in training and education. Interested applicants should apply to the Department Chairman, John Gilroy, M.D., F.R.C.P. (C), Department of Neurology, 3825 Brush Street, Detroit, Michigan 48201 (USA).

ANN ARBOR - YPSILANTI AREA. Three year AMA approved, university affiliated psych. residency offering comprehensive MH services to SE Michigan. Teaching faculty and supervisors include U. of M. faculty, private psychiatrists and analysts, as well as hospital staff. Resident's time divided approx. equally between didactic seminars (including supervision) and clinical experience. First year ADM & Intensive Treatment units; second and third year assigned Community Psych. and/or OPC and/or Children's Unit. Additional experience in psychosomatic medicine, Univ. Mental Hygiene Clinic, and neurology. 3-year: $10,669 to $12,131. 5-year: $12,152 to $21,944. $15,000 NIMH grants available eligible physicians in practice 4+ years. Contact: J. Tiziani, M.D., Ypsilanti State Hospital, Ypsilanti, Michigan 48197.

ANESTHESIOLOGIST to take charge 115 bed hospital in Southern Minnesota city, population 20,000, service area 40,000. Salary $50,000 plus. Also Anesthesiologist for 134 bed hospital in Central Illinois, population 40,000. $50-$60,000. Both fees paid. Send resume to American Medical Personnel, 159 East Chicago Ave., Chicago, Illinois 60611.

WANTED: Medical practitioner for private medical-industrial practice — Saginaw. Modern office, fully equipped — X-ray, diathermy, etc. Will introduce. Reason for leaving — retirement. Terms open. Reply Box #1, 120 W. Saginaw Street, East Lansing, Michigan 48823.

PEDIATRICIAN AND OBSTETRICIAN BOARD ELIGIBLE/CERTIFIED: to join six-man multi-specialty group in Northern Lower Michigan. New facility 1970. Professional corporation. Opportunity for many benefits, including disability, tax sheltered profit sharing and pension plans, life insurance, medical expense allowance. Base salary plus incentive first year, partnership two years. Excellent summer and winter recreation facilities in a growing community you would be proud to call home. Please contact R. J. Pranger, Manager, Medical Arts Group, P.C., Cadillac, Michigan.

DOCTORS — Munising, Michigan, has a drawing area of 10,000 people with its excellent schools, best water sports, and hunting in the Great Lakes and a 35 bed modern hospital with an ICCU, physical therapy, inhalation therapy, and surgery. There is an opening for a general surgeon or general practitioner who would like to do some general practice and surgery and work with a young general practitioner. The offices are located next to the hospital. If interested, contact Neil Grossnickle, M.D., Sand Point Road, Munising, Michigan 49862.

GENERAL SURGEON, General Practitioner, Internist and OB-GYN needed for established multi-specialty group in Detroit. Excellent professional relationship. Reply: Box #3, 120 West Saginaw Street, East Lansing, Michigan 48823.

OBSTETRICIAN-GYNECOLOGIST to associate with young certified O.B. Brand new hospital. Michigan Thumb recreation area. $22,000 first year, then full partnership. James M. Mullaney, M.D., 206 N. Heisterman, Bad Axe, Michigan 48413 (517) 269-7409.

POSITION DESIRED: General practice or locum tenens. Available July 5 through September 5, 1970. University of Michigan Medical School graduate with Michigan license. Rotating internship at Parkland Memorial Hospital, Dallas, Texas. Also interested in emergency room position. Write: Robert M. Williams, M.D., 2110 Belt Line Road 225-B, Carrollton, Texas 75006.

DOCTORS! Monroe, Michigan, City of 30,000 — County of 100,000. Located Lake Erie near Toledo, Detroit. Excellent schools, community college, 300 beds in two new hospitals. Openings for General, ENT, Urology, Orthopedic Surgery. Contact: R. W. Wilkins, M.D., Secretary Monroe County Medical Society, 118 Cole Road, Monroe, Michigan 48161

LAS PALMAS HOTEL, SOUTH ANDROS, BAHAMAS: Las Palmas Hotel with two miles of beach, 58 miles from Nassau and 180 miles from Miami. Here, just a quick boat ride away from south bight with its conch, bonefish, turtle and lobster, is Las Palmas Hotel. Each of its 20 guest rooms has its own patio and a view overlooking the ocean. Each is air-conditioned with two double beds and private bath. There is a big fresh water pool, a putting green, a driving range and shuffleboard. Also available are fishing boats, sailboats, glassbottom boats, snorkeling equipment and bone fishing gear. See your travel agent, or write direct to: Las Palmas Hotel, P.O. Box 800, The Bluff, South Andros, Bahamas.

PSYCHIATRIC RESIDENCIES: We offer nothing but excellent psychiatric training in a stimulating; well-organized program located in a culturally advantaged community. Approved psychiatric training. Traverse City State Hospital, Michigan Department of Mental Health. Three and five year programs. Salary, 3 year program: $10,669; $11,191; $12,131. 5 year program: $12,152; $14,031; $16,328; $21,944; $23.093. NIMH-GP stipends available. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

INTERNIST: Attractive well established practice available. Can promise excellent income from first day. Will rent or sell office building. Two blocks from 400 bed hospital. Western Michigan community of 125,000 on Lake Michigan. Hunting, fishing, and winter sports near by. Write Box #7, 120 W. Saginaw St., East Lansing, Michigan 48823.

COMMUNITY of 10,000 in Southern Michigan needs GP's and Pediatricians. Fully accredited Hospital with ICCU. Ideal family community located 30 minutes from Ann Arbor, 60 minutes from Detroit and 45 minutes from Toledo. Excellent schools and recreational facilities. Contact Larry T. Burch, M.D., 10 Cairns Street, Tecumseh, Michigan 49286.

NEW EXPANDING OPPORTUNITIES for family physicians and physicians specializing in pediatrics, general surgery, internal medicine, urology, anesthesiology; in medically awakening community. Contemporary, automated, 105-bed new hospital to be completed in the fall of 1970. Present hospital to be converted into long-term unit. Patient service area 50,000 people. Medical staff leading and supporting recruitment efforts. Excellent community location, forty miles equi-distant to Milwaukee or Madison. Complete educational, cultural and recreational facilities. A New medical-dental building to be built adjacent to the new hospital. Immediate satisfaction in practice, income and family living. Special assistance if needed. Write or call Leo C. Bargielski, Administrator, Watertown Memorial Hospital, 1301 E. Main Street, Watertown, Wisconsin, 53094; telephone (414) 261-4210 for more information.

FOR LEASE: Office space available for single or combined occupancy (total 3600 sq. ft.) in extremely attractive professional building in suburban northeast Grand Rapids. Will design space to suit. Abundant parking. Opportunity to live in lovely metropolitan area close to Michigan's finest fishing, hunting, sailing and skiing. Ten minutes from area hospitals. Phone Collect: Dr. Willard Wolfe (616) 363-3821.

RADIOLOGIST AND INTERNIST in a 200 bed modern, progressive general hospital in beautiful residential community. Salaries dependent on qualifications, ranging from $19,767 to $25,189. Excellent fringe benefits. License in any state required. Can pay moving expense. Equal opportunity employer. Write Hospital Director, Veterans Administration Hospital, Fort Wayne, Indiana, or call (219) 743-5431, Ext. 10.

MEDICAL TECHNOLOGISTS: Also Microbiologist and Cytologist ASCP registered or eligible. Modern clinical laboratory. Starting salary $658.00 per month with increases to $830.00 per month. A shift differential and weekend differential is paid. Excellent fringe benefits include tuition reimbursement, paid vacations, insurance and holidays. Write or call collect (487-6111 Ext. 353). Edward W. Sparrow Hospital, Personnel Department, 1215 E. Michigan Avenue, Lansing, Michigan 48912.

EXTREMELY BUSY two man group needs OB man, who is willing to do some general practice, or a GP who particularly wants to do OB. New modern 80 bed hospital with CCU unit. Small town in Northern Michigan, serving an area of about 12,000 people. Office space available, and financial arrangements entirely open to discussion. P.C. possible. Write Box 12, 120 West Saginaw Street, East Lansing, Michigan 48823, or phone (517) 846-6122.

PHYSICIANS: To fill immediate vacancies. Two positions available in program of medical review, nursing evaluation and level of care determination in certified health facilities. Salary range $22,258 to $29,023 depending on qualifications. All Michigan Civil Service benefits, including an outstanding state contributory insurance program, excellent retirement plan, longevity bonus, unlimited opportunities for personal advancement, and liberal vacation and sick leave allowance, plus social security. Must have current license to practice medicine or osteopathic medicine in Michigan and five years of professional experience as a practicing physician preferably in general practice, internal medicine, geriatrics, public health or medical care administration. Send Resume to Mr. Richard D. Crable, chief, recruitment and placement, Michigan Department of Civil Service, Lansing, Michigan 48913. An equal opportunity employer.

GENERAL PRACTITIONER – SURGEON: Community in southern, central Michigan Resort area has need for several doctors. Two doctors recently retired. New, modern, all-accredited hospital. Good hunting, fishing and lake area. Large, new artificial lake now under construction. For additional information call: (313) 448-2371 or write L. E. Weight, Secretary, Board of Trustees, Thorn Hospital, Hudson, Michigan 49247.

PSYCHIATRIST, Board eligible, trained in Michigan and licensed in Michigan. Broad experience in all forms of psychiatry treatment, wants to solo associate with the psychiatric unit of a general hospital. Guaranteed income first year. Reply Box #9, 120 West Saginaw Street, East Lansing, Michigan.

WANTED: Internist to join two man partnership in Michigan's upper thumb area. Excellent recreation and educational facilities are available. Write to: K. G. Herrington, M.D. or Kenneth S. Kube, M.D., 669 South Van Dyke, Bad Axe, Michigan. May call collect: (517) 269-6453.

PEDIATRICIAN: Age 31, university trained, Board Certified, solo practice for two years, seeks relocation. Desire partnership or association. Reply Box #8, 120 West Saginaw St., East Lansing, Michigan 48823.

in memoriam

DeWitt T. Burton, M.D.
Detroit

DeWitt T. Burton, M.D., the first Negro in Michigan history to achieve statewide office, died Feb. 17 at the age of 77.

Doctor Burton

Doctor Burton made history in 1959 when he was elected to a two-year term on Wayne State University's Board of Governors. He was re-elected to a six-year term in 1962, retiring from the board in 1968. He remained active as director of Burton Mercy Hospital, Detroit, which he founded in 1952.

Doctor Burton was graduated from Meharry Medical College and was a past chairman of the Detroit Urban League, past chairman of the United Negro College Fund in Detroit and a member of the national board of directors and an executive board member of the Detroit Council of the Boy Scouts.

Doctor Burton organized a scholarship fund for African students at Wayne State University, was a past board member of the United Foundation, World Medical Relief Organization and the NAACP in Detroit. He was also superintendent of the Wayne Diagnostic Convalescent Home in Detroit.

Harold F. Closz, M.D.
Muskegon

Harold Francis Closz, M.D., Muskegon physician and surgeon for 42 years, died Feb. 13 at the age of 79.

Former chief of staff at Hackley Hospital, Muskegon, Doctor Closz was graduated from Central Iowa College School of Medicine and was awarded an honorary doctorate from Central College.

Doctor Closz, who retired in 1964, was former president of the Muskegon County Medical Society. He was a fellow of the American College of Surgeons and the Academy International of Medicine. He was also affiliated with Mercy Hospital in Muskegon.

Fred J. Drolett, M.D.
Lansing

Fred J. Drolett, M.D., Lansing, the oldest practicing Ingham County physician when he retired in 1966, died Feb. 18 at the age of 91.

Named Michigan's Foremost Family Physician by MSMS in 1958, Doctor Drolett was a past president of the Ingham County Medical Society. He had served as chief of obstetrics at St. Lawrence and Sparrow Hospitals and chief of St. Lawrence Hospital in Lansing. He had delivered more than 6,000 babies, including the first to be born at Lansing's Sparrow Hospital.

Doctor Drolett was graduated in 1907 from the Detroit College of Medicine and began his practice driving a horse and buggy. He was a member of the American Academy of General Practitioners and received the local Elks Club's Outstanding Citizen Award in 1957 for 50 years of community service. His first career was as a master bookbinder.

L. Warren Gatley, M.D.
Birmingham

L. Warren Gatley, M.D., physician and surgeon affiliated with Pontiac General and St. Joseph's Mercy Hospitals, died Jan. 26 at the age of 69.

Doctor Gatley was a graduate of St. Louis University School of Medicine and was a fellow of the American College of Surgeons and of the American College of Abdominal Surgeons.

D. H. Kaump, M.D.
Ann Arbor

D. H. Kaump, M.D., director of toxicology and pathology at the Parke, Davis and Co. research laboratories in Ann Arbor, died Feb. 13 at the age of 62.

Doctor Kaump was former consulting pathologist and chief of the Department of Pathology at Providence Hospital, Detroit, and a former consulting pathologist for Wayne County. He had served also as associate professor of pathology at the Wayne State University College of Medicine and was a lecturer in pathology at the University of Michigan Medical School.

He was a founding fellow and past governor of the College of American Pathologists and a past president of the Detroit Institute for Cancer Research. He was graduated from the Washington University School of Medicine in St. Louis.

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William J. Kofmehl, M.D.
Stambaugh

William John Kofmehl, M.D., Stambaugh general practitioner for nearly 60 years, died Jan. 10 at the age of 82.

A graduate of Rush Medical College, Doctor Kofmehl was a past president of the Dickinson-Iron County Medical Society. He was affiliated with Stambaugh General Hospital.

William A. Mudge, M.D.
Negaunee

William Albert Mudge, M.D., Negaunee general practitioner since 1916, died Jan. 28 at the age of 84.

Doctor Mudge was graduated from the University of Illinois School of Medicine and served as City of Negaunee health officer from 1924 to 1939. In 1966, he received a certificate from President Lyndon Johnson and Gov. George Romney for 25 years of service to the nation as an uncompensated member of the Selective Service System.

He was former vice president of the Marquette-Alger County Medical Association.

Paul Van Riper, M.D.
Champion

Paul Van Riper, M.D., Champion, at 94 one of Michigan's oldest practicing physicians, died Feb. 16. He began practice in Champion in 1901, after graduation from the University of Michigan Medical School.

Doctor Van Riper was named Michigan's "Foremost Family Physician" in 1957 by MSMS and received the honorary degree of doctor of humane letters from Northern Michigan University in 1964.

Doctor Van Riper served for 35 years on the Marquette County Board of Supervisors and was secretary of the Champion Board of Education for 35 years. He also donated land along Michigamme Lake for a state park which is named in his honor.

He was affiliated will Bell Memorial Hospital in Ishpeming.

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Number of patients	Mean initial value	Mean final value
14	3.23	4.83
16	3.50	4.40
25	4.52	4.47

K-Lyte can offer effective potassium supplementation without the gastrointestinal complications sometimes associated with potassium chloride tablets and thiazide-potassium chloride combination therapy. Effervescent K-Lyte is taken in solution, speeding up absorption to avoid these hazards.

Composition: Each tablet contains potassium bicarbonate (2.5 Gm.), citric acid (2.1 Gm.), cyclamic acid, artificial flavor and color.
Contraindications: When renal function is impaired, or if the patient has Addison's disease, potassium supplementation should not ordinarily be instituted.
Precautions: Should not be used in patients with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations.
Side Effects: While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum.
Administration and Dosage: K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement.
How Supplied: Effervescent tablets—boxes of 30 and 250 (orange or lime).

*Reports on file: Medical Research Department, Mead Johnson Laboratories, Evansville, Indiana 47721

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BY HERB AUER, EXECUTIVE EDITOR

In a recent editorial, entitled "It's Time for Action on Doctor Shortage," the *Saginaw News* declared:

"We know that the MSMS is aware of the shortage in the paraprofessional field. It has been among the prime movers in seeing to it that MSU will offer training in these medical-related fields. We believe also that it recognizes the need for family physicians and supports an educational emphasis in that direction."

* * *

"The medical profession is being looked to for leadership, and medical education is committed to devote careful attention to developing and implementing health plans to meet society's needs." So states the 1969 annual report of the Kellogg Foundation, which is financially assisting many medical schools.

The Foundation report also states that "The problems of maintaining quality and effectiveness of health services and making them more generally available to the public at a reasonable cost require the full participation of the medical schools of the country."

* * *

Dale Williams, M.D., is chairman of a Muskegon County Medical Society effort to recruit more doctors for the Port City county. President Ralph F. Askam, M.D., in the county *Bulletin,* challenges the members "to visit our old schools and interview prospects — much as we did with Interns. We must find some access to the returning Military Medics. Local people in Medicine elsewhere should be located and contacted." Doctor Askam notes the campaign as the "No. 1 Project."

* * *

To approach our public problems, "we need the much deeper involvement of business and professional people," Peter B. Clark, publisher of the *Detroit News,* recently told the Detroit Economic Club.

"Your value judgements should be more forcefully expressed," Mr. Clark said. He continued:

"Some writers to the contrary, there are no experts on right and wrong! You should not hang back, for no one knows 'what ought to be' better than you do.

"The thrust of my remarks has been the need for the attitudes, skills and judgements which you possess. You are highly educated but are not the captives of education. You have had practical experience with complex human affairs, but you realize that purpose must always guide technique. You retain, I trust, youthful idealism but you see the limitations of idealism untempered by realism. With your involvement we can do substantially better than we have done."

* * *

"Failure to heed some plan of communication, especially in the past decade, has led to grave misunderstandings, to hindrance of work, and damage to the public image of both physicians and scientists."

So says Irvine H. Page, editor-in-chief of **Modern Medicine.** Doctor Page contends all physicians have a stake in the resolution of this problem, because most people turn to physicians for information about medical matters. If the physicians are not well informed, the public ultimately will suffer.

* * *

Physicians for centuries have called attention to the potential dangers of pollution. The following was not written today, but back in 1878 by Robert C. Kedzie, M.D., who served as president of MSMS in 1874 and who was a member of the State Board of Health which MSMS helped to create:

"The subject of the pollution of streams by sewage is a question of great importance in reference to the public health; but it is one that must be considered and settled before sewer systems become practically beyond control on account of the large outlay of money necessary to effect a change.

"The inertia of cities and corporations on such subjects, when any radical change involves the throwing away of the large sums already invested and the expenditure of still larger sums in new systems, and for so intangible and impersonal a matter as the public health, will prove an impassable barrier to desirable changes in the future."

This is quoted from in the 1878 annual report of "The Work of the State Board of Health" presented on April 3, 1878.

michigan medicine

FEATURES IN THIS ISSUE

Hospital Costs and the Physicians Role
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Special 7-Page Section Highlights
Michigan Week
May 16-23

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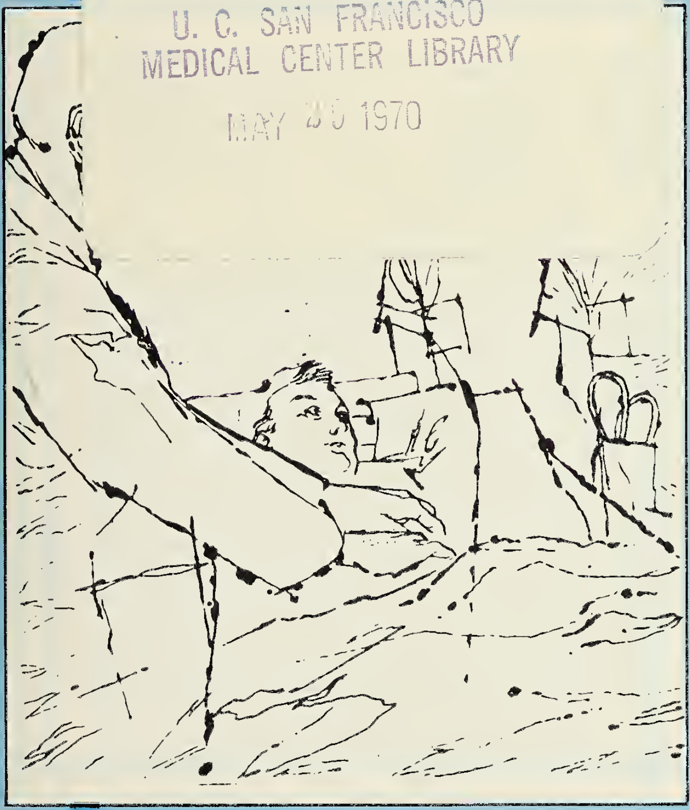

Michigan Hospital Week
May 10-16

Michigan State Medical Society
May 1970, Volume 69, Number 9

MSMS 1970 Annual Session Sept. 20-21, Detroit

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Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. *Sympathomimetic cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic* phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.
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April 1970, Volume 69, Number 8
Michigan State Medical Society

michigan medicine

Doctor Reizen to Take Over State Health Post On May 4; Succeeds Doctor Rice

Doctor Reizen

Maurice S. Reizen, M.D., Lansing, will take over duties May 4 as director of the Michigan Department of Public Health.

He was appointed March 31 by Gov. William G. Milliken to succeed Robert G. Rice, M.D., public health director since April 19, 1968. Doctor Rice resigned to take his former position as bureau chief of maternal and child health.

Until Doctor Reizen, director of the Ingham County Health Department since 1966, takes over, Kenneth Wilcox, M.D., director of the state department's Bureau of Laboratories, will be acting state public health director.

Doctor Reizen, 51, a specialist in general preventive medicine and public health, holds a master's degree in public health from the University of Michigan, a teacher's certificate from Wayne State University and his M.D. degree from the University of Rochester.

He had hospital administration experience in the U.S. Air Force, and practiced medicine for 15 years in Warren. During his years as Ingham County Health Director, helped develop additional immunization clinics and establish V.D. and family planning clinics and a child health center for the disadvantaged.

Doctor Reizen is a former president of the Macomb County Medical Society and was that society's delegate to the MSMS House of Delegates for three years. He is currently chairman of the MSMS Public Health Committee.

"Our health needs for this decade may well dwarf the needs of previous decades," said Gov. Milliken on making the appointment. "We are indeed fortunate that a person of Doctor Reizen's high caliber will head such a vital department as Public Health.

"Doctor Reizen possesses the unusual and admirable combination of keen social awareness, medical expertise and experience in hospital administration and public health."

Said Robert J. Mason, M.D., Birmingham, MSMS president, of Doctor Reizen's appointment: "We are fortunate in having Doctor Reizen in this high position of medical prominence. His performance in the private practice of medicine, in lesser public health positions and with the MSMS, as chairman of both our Section and our Committee on Public Health, has been uniformly superlative."

Doctor Anderson Resigns as Mental Health Director

Dr. Anderson

William H. Anderson, M.D., director of the Michigan Department of Mental Health, will step down from his post June 30. He submitted his resignation to Gov. William Milliken on April 8.

Doctor Anderson submitted his resignation to Gov. Milliken early in 1969, but the governor convinced him to stay on then. Doctor Anderson said he agreed to stay last year "in order to determine what progress could be made on some improvements, efforts that were then in a formative stage.

"It is my opinion that at least the groundwork has been laid for effective and progressive change in the Department of Mental Health if certain efforts now underway can be kept in motion," said Doctor Anderson on his resignation.

Doctor Anderson was superintendent of the Mid-Missouri Health Center and an associate professor of psychiatry at the University of Missouri at the time of his appointment as Michigan's mental health director.

Medical Assistants 20th Annual Meeting April 23-25 at Pontchartrain Hotel, Detroit

The American Association of Medical Assistants, State of Michigan, will stage its 20th annual convention, "The Sophisticated Seventies," April 23-25 at the Pontchartrain Hotel, Detroit.

It will be the first medical assistants convention to be held in the spring. Previous meetings were held in conjunction with the MSMS Annual Session in the fall.

Miss Margaret Broadwell of Detroit is convention chairman, assisted by Miss Lydia Lojowski, also of Detroit, who is handling convention registrations.

The medical assistants will elect new officers, present awards to the component societies with the greatest gain in membership and the best bulletins during the year, honor past officers and outstanding members.

Speakers for educational meetings and their topics will include John Derr, M.D., Royal Oak, "Growth and Development of Surgery"; Tommy N. Evans, M.D., chairman of the Wayne State University Department of Obstetrics and Gynecology, "What's New in Gyn"; Benjamin Wailes, M.D., "Oncology," and the Rev. Paul Blomquist, "Priesthood of Personhood."

Outgoing president of the medical assistants is Mrs. Mary Jordan of Eaton Rapids. Current Speaker of the House is Miss Marlouise Redman of Harper Woods.

Michigan Diabetes Association Sets Annual Meeting

The annual meeting of the Michigan Diabetes Association will be held at 6:30 p.m. May 13 at the Oakland Community College, Orchard Ridge campus.

The guest speaker will be Frederick C. Goetz, M.D., Professor of Medicine, University of Minnesota Medical School. His subject will be "Pancreatic Transplants for Diabetics — A Realistic Appraisal."

Dinner reservations may be obtained by writing to the Michigan Diabetes Association, 6131 West Outer Drive, Detroit 48235.

Medical Education Foundation Re-elects Officers; Makes 1970 Grants

Doctor Towsley

All officers for the 1969-70 year were re-elected for the 1970-71 year by members of the Michigan Foundation for Medical Education at their annual meeting recently in Detroit.

Continuing as leaders of the organization are Harry A. Towsley, M.D., Ann Arbor, president; Warren F. Tryloff, associate MSMS executive director, secretary, and Herbert Gardner, retired bank official from Birmingham, treasurer. Mr. Gardner and A. Stewart Kerr, Detroit, MSMS legal counsel, continue to serve as trustees, while two new trustees elected are Robert J. Mason, M.D., Birmingham, MSMS president, and Robert K. Whiteley, M.D., Detroit, member of The Council of MSMS.

The foundation also made 1970 grants to the following organizations, in the indicated amounts:

BRUCE FUND		
Central Hospital Council of Saginaw		$ 150.00
University of Michigan Pediatric Fellowship		5,038.77
		$ 5,188.77
GENERAL FUND		
Michigan Health Council		$ 2,750.00
Michigan Health Conferences	$1,000.00	
Michigan Medical Manpower Study	1,000.00	
Health Careers Mobile	750.00	
Student Aid Committees:		
University of Michigan Medical School		3,133.88
Wayne State University School of Medicine		2,700.00
Michigan State University College of Human Medicine		1,800.00
		$10,383.88

Constructive Approach to Grief Topic of Wayne County Medicine-Religion Meeting

A crowd of 80 Michigan physicians and their clergymen gathered April 1 at Wayne County Medical Society headquarters in Detroit for a medicine and religion meeting sponsored by MSMS and the Wayne County Society.

They heard the Rev. Granger E. Westburg of the Hamma School of Theology, Wittenberg University, describe 10 stages of grief and advise them to help patients and parishioners "grieve not as those who have no hope — but grieve."

Moving at the right pace through the stages of grief can be a creative and productive experience, "provided we move through grief with the help of our faith and the supporting concern of those around us," said the Rev. Mr. Westburg, who discussed "Good Grief — A Constructive Approach to the Problem of Loss."

Other phases of the meeting included an afternoon workshop led by The Rev. Dr. Paul B. McCleave, head of the AMA Department of Medicine and Religion; a panel discussion by physicians and clergymen and reports of county medical society medicine and religion activities.

The only M.D. physician on the Board of Trustees of the New Detroit Committee, Brock E. Brush, M.D., right, chairman of the MSMS Committee on Public Relations, is pictured meeting with fellow New Detroit trustees, from left, Jack Wood, secretary-manager of the Detroit and Wayne County Building Trades Council; Mrs. Jean Washington, of the Detroit Police Community Relations Committee; Michigan Senator Emil Lockwood, St. Louis.

Award-Winning Medical News Writer To Deliver Annual Yates Lecture

Miss Mildred Spencer, medical news writer for the *Buffalo Evening News* of Buffalo, N.Y., will deliver the 1970 Yates Memorial Lecture at the Conference on Medical Reporting planned May 18 at Kellogg Center, Michigan State University.

Miss Spencer has received many national awards including an American Medical Association award for medical science writing. Her topic will be "A Medical Writer Does His Thing."

Sponsoring the conference will be MSMS, the Michigan Press Association, the MSU Schools of Journalism, Nursing and Veterinary Medicine, the MSU College of Human Medicine and Institute of Biology and Medicine, and the Michigan TB and Respiratory Disease Association, which presents the Yates Lecture.

State Medical Board Exams June 16-18 To Use FLEX Form for First Time

Physicians seeking license to practice in Michigan will take their state board examinations June 16, 17 and 18 at the Civic Center in Lansing. Applications and a fee of $75 were due April 1 at the office of the Michigan Board of Registration in Medicine.

At the June tests, the FLEX (Federal Licensure Examination) will be given in Michigan for the first time. It will replace the former Michigan licensure examination and is given in 21 states which have subscribed to the program under the supervision of the Federation of State Medical Boards of the United States.

Special Activities During Cancer Control Month Planned by Michigan Cancer Organizations

Special activities are planned by the Michigan Cancer Foundation and the Michigan Division of the American Cancer Society to mark Cancer Control Month during April.

The Michigan Division of the Cancer Society sponsored its annual Cancer Conference for Nurses April 9 at Towsley Center, The University of Michigan. The focus was on "Cancer in Children."

The Michigan Cancer Foundation, in cooperation with Wayne State University's School of Medicine, will conduct a Symposium on Cervical Cancer April 24-25 at Wayne County Medical Society headquarters.

Toronto Surgeon, Developer of "Mustard Operation," Headline Speaker for MHA's Heart Days

William T. Mustard, M.D., Toronto surgeon, will be the speaker for the annual Wilson-Myers Lecture, a feature of the Michigan Heart Association's Heart Days and Scientific Sessions May 7-9 at Detroit's Cobo Hall.

Doctor Mustard is internationally known as the inventor of the "Mustard" operation, the only hope for children born with transposition of the great arteries. Doctor Mustard used a piece of the patient's pericardium to make a bafflement which reverses the flow within the heart so that blood from the right atrium goes to the left ventricle. The flow of blood also becomes reversed and the two wrongs make a right.

The sessions will open with a day-long program on stroke, including rehabilitation and nursing care.

Police Investigating Breakage of 34 Windows In MSMS Headquarters Building

The Michigan State Medical Society reported on April 1 to the East Lansing Police Department the malicious destruction of 34 windows at the rear of the building. Damage was estimated at several thousand dollars. New windows were installed immediately.

The thick glass windows in the revolving door, several small windows at the lower-level loading area and most of the main floor windows were smashed. Two signs were scrawled on the building, apparently with a spray paint can, spelling out "Free Medical Care" and "Power to the People."

Michigan State University reported several windows broken the same night in the Administration Building. East Lansing police are investigating.

Wayne County Medical Society Council Endorses Two Healthoramas for Detroit

The Council of the Wayne County Medical Society is one of several Detroit-area organizations endorsing the two Healthoramas planned this year for residents of Wayne, Oakland and Macomb Counties.

The Wayne Council gave its official approval at a meeting April 3 and followed its move by sending a letter to the United Foundation, which has sponsored the Healthoramas in 1968 and 1969.

Because of the success of those earlier events, the Foundation has decided to hold two separate Healthoramas in 1970. The first will be May 13-16 in the Community Arts Building at the State Fairgrounds and the second will be June 3-6 at Outer Drive Hospital in Lincoln Park.

Comprehensive health screening tests, made possible through the cooperation of voluntary and public health services, will be offered at both events daily from 9:30 a.m. to 5 p.m. More than 13,000 persons have been screened at Healthoramas in the past two years.

ARTHUR WEAVER, M.D., a Detroit physician who has helped thousands of persons stop smoking, got a boost to his campaign when a well-known **Detroit News** columnist, Doc Greene, left, joined a smoking withdrawal clinic. Doctor Weaver described the effects of smoking on the heart (left) to Doc, who agreed to try a five-day withdrawal plan of deep breathing, exercise, drinking water and fruit juice and vowing "I choose not to smoke." Ninety percent of those attending his clinics actually stop smoking, Doctor Weaver says.

Medical Education Technology Topic of Detroit Meeting April 28

Physicians who teach or are involved in mass communications are invited to a special day-long session on "Medical Education Technology" planned April 28 as part of the national convention of the Audio-Visual Instruction Department of the National Education Association.

The morning and afternoon sessions will take up the subjects of instructional technology, medical education today, teaching carrels in gynecology and obstetrics, computer-aided simulation of the medical encounter, a media-based approach to teaching doctor-patient relationships and the teaching of decision-making to nursing students through programmed media.

Regional Medical Programs Advisory Group Elects Doctor Brennan, Approves Three Projects

Doctor Brennan

The Regional Advisory Group (RAG) of the Michigan Association for Regional Medical Programs recently elected Michael J. Brennan, M.D., Grosse Pointe, as its chairman for the coming year.

The RAG appropriated $40,514 until Aug. 31 to fund the Western Michigan Medical Education Project, administered by Blodgett Hospital, Grand Rapids, and approved by the National Advisory Council.

The RAG also approved renewal of Wayne State University's Surveillance of Electronic Equipment project, reapproved the Wayne County General Hospital's Comprehensive Health Care for the Urban Poor program and approved a new Wayne State University Southeastern Michigan Regional Cancer Program to establish programs for physicians, nurses and other health professionals in the latest techniques of cancer treatment.

All three projects must now seek federal approval before implementation.

AMA Plans Environmental Health Meeting May 4-5

"The Population Problem and The Physician" is the theme chosen for the AMA Congress on Environmental Health, May 4-5 in Washington, D.C. The program has been planned by the AMA Council on Environmental and Public Health, which includes Otto K. Engelke, M.D., Ann Arbor, as an active member.

Thursday, April 30, 1970

Towsley Center
The University of Michigan
Medical Center
Ann Arbor, Michigan

1970 Conference On Medical Aspects Of High School Sports

Sponsored by the Michigan State Medical Society and the University of Michigan Postgraduate Medical Center.

High School team doctors, coaches, trainers and school administrators will confer Thursday, April 30 at the Towsley Center for Continuing Medical Education at the University of Michigan Medical Center, Ann Arbor. The occasion will be the "Fifth Annual Conference on the Medical Aspects of Michigan High School Sports."

The registration fee will be covered by the conference sponsors. The luncheon will be $3.25.

9 to 9:30 a.m.
Registration, second floor lobby, Towsley Center.

9:30 to 10:30 a.m.
"Diagnosis and Management of Athletic Injuries to the Shoulder Girdle"
Kenneth Saer, M.D., Team Physician, Orthopaedic Surgeon, Tulane University Athletic Teams, New Orleans Saints Professional Football Team

10 to 10:30 a.m.
"Demonstration and Discussion of Knee Reconditioning Techniques for High School Athletes"
J. Lindsay McLean, R.P.T., Head Trainer, University of Michigan Athletic Department

10:30 to 10:45 a.m. Intermission

10:45 to 11:45 a.m.
"Pre-Season Conditioning Program for High School Athletes"
Panel moderated by William E. Newell, R.P.T., Head Trainer, Purdue University Athletic Department, Lafayette, Ind.; with Walter Kanicki, Athletic Trainer, Bay City Central High School; Fred Snowden, assistant basketball coach, University of Michigan Athletic Department; Larry Smith, assistant football coach, University of Michigan Athletic Department

Noon to 1 p.m. Luncheon

1 to 1:30 p.m.
"Relationship of Athlete Administrators and Coaches to Medical Advisors"
Donald B. Canham, professor of physical education and athletics and Director of Athletics, University of Michigan

1:30 to 2:15 p.m.
"Management of Some Common Injuries in Contact Sports"
Kenneth Saer, M.D.

2:15 to 2:45 p.m.
"Management of Acute Facial Injuries in Contact Sports"
Reed O. Dingman, M.D., professor of plastic surgery, University of Michigan Medical Center

2:45 to 3:15 p.m.
"Experimental and Applied Studies of Head Protection in Contact Sports"
Hank A. Gosch, M.D., Neurosurgery Section, University of Michigan Medical Center; Richard C. Schneider, M.D., professor of neurosurgery, University of Michigan Medical Center; Alwin Gooding, Neurosurgery Section, University of Michigan Medical Center

3:15 to 4 p.m.
"Helpful Hints in the Management of Unusual Training Problems"
William E. Newell, R.P.T.

REGISTRATION FORM

Return to: MEDICAL ASPECTS OF HIGH SCHOOL SPORTS
Department of Postgraduate Medicine
The University of Michigan Medical Center
Towsley Center for Continuing Medical Education
Ann Arbor, Michigan 48104

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STATE____________________ZIP________________

I would like __________ tickets for the luncheon on May 8. ($3.25 each) The registration fee will be paid by the sponsors of the conference.
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An Editorial About Blue Shield

BY BROOKER L. MASTERS, M.D.
CHAIRMAN
MSMS PUBLICATION COMMITTEE

All doctors of Michigan have received a letter from Michigan Medical Service announcing several things: 1) Elimination of further changes in customary charge profiles of physicians; 2) Selective adjustments in prevailing screen levels; and 3) Financial reserves of Michigan Blue Shield at less than $7 million at the end of December, 1969.

Translated this means: 1) A freeze on your charge levels; 2) A roll-back in some of your fees; and 3) that Blue Shield is broke. Any insurance organization paying out more than $17.5 million per month in benefits cannot be considered solvent if its reserves are less than one month's obligations.

Furthermore, you have recently received a notice of new rate increases, for your own hospital-medical coverage. There are scheduled at least two more rate increases for the remainder of 1970, provided the Insurance Commissioner approves them. The present rate increases mean an outlay of approximately $50 per month for a family Blue Cross/Blue Shield coverage.

IF YOU THINK $600 per year for prepaid medical-hospital coverage is quite a bite out of your income, think what it means to the average wage earner. Or more so, what it means to industry which pays the whole package for each of its workers, as a fringe benefit.

But more, industry and the individual wage earner are now seriously questioning whether they can go on paying this cost, particularly when it covers much less than the total medical bill for an average family per year.

Whether we like to admit it or not, the medical profession is the one group receiving the major share of the blame for the escalation of health care costs.

Somehow the public does not comprehend the enormous rise in hospital costs, the price of our modern drugs, the unbelievable rise in demand for services in the face of an ever-increasing shortage of purveyors of those services; no, it is you, Doctor, who is responsible. By inference, then, it is you who is making all this money? Therefore, despite ever-increasing costs of doing your business, you can "afford" a freeze in your income, even a roll-back!

If this isn't enough, the corporate image of medicine is at its lowest level, both nationally and in the legislatures throughout the nation.

All of these facts are known to all doctors who read, watch TV, or listen to their patients. I wonder if it is equally apparent that these things just cannot go on without some attempt at settlement. Nearly all citizens have been sold the idea that health care is a right. It seems ironic that those who must provide that care are so left out of the thoughts and considerations by those who will legislate the solutions of these dilemmas. For there is little doubt that the formula for health care in the future will come out of the halls of Congress and our state legislatures, and soon.

BLUE SHIELD BROKE?! Whatever the reasons — and every one of us has his own version of why — there is no doubt that the Blues have provided the bulwark of the private-pay sector against the demands for more and more governmental financing of health care. Whatever may have been — and still are — valid criticisms of the Blue plans fade into insignificance when one realizes that the only alternative today is Universal Health Insurance. I believe that the people want something of this sort. Certainly they are being told by Reuther and many Congressmen that it is needed and is their right.

Blue Shield broke! If there is any alternative it would seem that it demands the thoughtful actions of every member of the medical profession to work for and provide a statesman-like solution to this Blues crisis of 1970.

michigan medicine

MICHIGAN STATE MEDICAL SOCIETY

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Breaking News
May 1970, Volume 69, Number 9
Michigan State Medical Society

michigan medicine

New MSMS Committee Formed On Utilization Review and Health Insurance Problems

A new MSMS Committee on Utilization Review and Health Insurance Problems is being formed with Robert C. Prophater, M.D., Bay City, serving as chairman.

The committee will serve as an appeal mechanism for the Regional Medical Advisory Committees and thus serve as the MSMS utilization committee.

It will be concerned with frequency of use patterns, based upon data supplied by Michigan Medical Service and it will discuss with the officials of Michigan Medical Service serious questions and reports that require more intense study than is possible during monthly Blue Shield reports to The Council.

Possible items of discussion are greater involvement of physicians in the control of fee escalation; greater involvement of MSMS in utilization review; mutual exploration of alternative techniques for control of rising charges; consideration of a voluntary control for Medicaid such as acceptance of average payments rather than prevailing screens, and discussion of the tendency of groups to probe the screens and raise average charges to prevailing levels.

The committee's first meeting with Blue Shield officers took place April 14 at MSMS Headquarters. On the committee are Hugh T. Caumartin, M.D., Saginaw; Paul J. Connolly, M.D., Detroit; Charles E. Darling, M.D., Detroit; A. Jackson Day, M.D., Detroit; Worth W. Henderson, M.D., Royal Oak; Robert M. Leitch, M.D., Union City, and Sydney Scher, M.D., Mt. Clemens.

Wayne Clinic Days May 13-14 Still Open for Interested Physicians

Interested physicians who have not made reservations yet for the Wayne State Medical Alumni Clinic Days are urged to contact Alumni House, Wayne State University, Detroit 48202. The two-day event is scheduled May 13-14 at Cobo Hall, Detroit.

All sessions of the Clinic Days are free, as well as luncheons both

Don't Miss Special Michigan Week and Hospital Week Articles Inside

days. The only charge is $30 per couple for doctors and $15 per couple for residents for the banquet.

Major speakers will be Jerome Pollack, M.D., associate dean for medical care planning at Harvard University, and a representative of the Health, Education and Welfare Department. Roger O. Egeberg, M.D., HEW assistant secretary, has been invited. Both men will discuss "The Role of the Federal Government in Providing Medical Care."

M. A. Riley, MSMS Legislative Counsel, Takes New AMA Post in Portland, Ore.

Mr. Riley

M. A. Riley, MSMS legislative counsel since December, 1960, assumed new duties beginning in May as AMA field service officer for the states of Alaska, Idaho, Montana, Oregon and Washington. His home office is now in Portland, Ore.

Mr. Riley has served MSMS as staff assistant to the MSMS House of Delegates, chief lobbyist, staff assistant to the MSMS Legal Affairs Committee and a key member of the MSMS operating staff.

Members of the Legal Affairs Committee, through chairman Otto K. Engelke, M.D., Ann Arbor, formally expressed their appreciation for Mr. Riley's service at their April 16 meeting just before his departure.

They gave him a standing ovation, and in a message to The MSMS Council, cited Mr. Riley for his skill as a legislative representative and his devotion to the objectives of Michigan medicine. They also noted that Mr. Riley's departure would be felt in more personal ways by the many physicians and officers who have shared his friendship.

MSMS Workshop For County Society Leaders Part of Medical Triple-Header May 20-21 In Lansing

A special afternoon and evening workshop on vital issues in the practice of medicine will be presented for county medical society leaders May 20 at MSMS Headquarters. In charge of the annual event, which will include dinner, will be MSMS officers and staff.

The MSMS Council on April 21 approved the workshop, which will be offered as part of a two-day triple-header series of events in Lansing for leaders of Michigan medicine.

The other two events will be a Public Speaking Workshop May 20 at the Michigan Education Association building in East Lansing, and an all-day Critical Health Problems Conference at the Lansing Civic Center May 21.

Coller-Penberthy-Thirlby Medical Conference July 30-31 in Traverse City

A total of 30 speakers, representing all three of Michigan's medical schools, and including nine from out-of-state, will appear at the 1970 Coller-Penberthy-Thirlby Medical Conference. The meeting will take place July 30-31 at the Park Place Motor Hotel in Traverse City.

Major events will include a panel discussion of surgical problems and a dinner address by the director of University Hospital, Ann Arbor, Edward J. Connors.

James Hall, M.D., Traverse City, is general chairman of the meeting, while A. James French, M.D., Ann Arbor, is program chairman. They expect a registration of 350 persons.

Make A Date To Attend 1970 Annual Session

Every Michigan physician is urged to attend the 1970 MSMS Annual Session Sept. 20-24 at the Sheraton-Cadillac Hotel, Detroit. Program chairman Alexander J. Walt, M.D., Detroit, announces that a new feature of the Scientific Sessions will be an 11 a.m. Annual Discourse, featuring a speaker of national prominence who will discuss vital medical problems. Be sure not to miss it.

Doctor Walt

Upper Peninsula Medical Society Plans 75th Annual Meeting June 18-20

A complete scientific program and an entertaining schedule of recreational events for the physician's family will be combined in the 75th annual meeting of the Upper Peninsula Medical Society June 19 and 20 at the Ojibway Motor Hotel, Sault Ste. Marie.

Registration will begin Thursday evening, June 18, in the hotel lobby, followed by a cocktail party and dinner for exhibitors. On Friday and Saturday morning a full schedule of scientific meetings has been arranged.

Saturday afternoon is free for leisure activities, including golf, a tour train, visits to the Shrine of Missionaries, the International Bridge and the Freighter-Valley Camp and a 5 p.m. boat trip through the Soo Locks. A dinner-dance is planned Friday evening.

Topics of scientific talks will include management and prevention of hemotoxic drug reactions, pulmonary contusions, injuries of peripheral nerves, surgical management of the infertile patient, obstetrical eponyms, nuclear medicine and brain complications in children.

Further information may be obtained from W. F. Mertaugh, M.D., Sault Ste. Marie, president of the Chippewa and Mackinaw County and Upper Peninsula Medical Societies.

Blue Shield President Proposes Major Medicaid Changes

Sweeping changes in Michigan's Medicaid program were proposed April 16 by Michigan Blue Shield President John C. McCabe, in testimony before the House Appropriations Subcommittee on Social Services. The subcommittee is considering revision of the program in Michigan.

Mr. McCabe proposed transfer of control of Blue Shield from the Department of Social Services to the Department of Health, the formation of a cost control commission reporting directly to the governor through the director of the budget, and the barring of any "provider" convicted of fraud from any Medicaid participation.

Mr. McCabe told the subcommittee that the state could improve its efficiency and cut Medicaid costs by adopting certain regular Blue Shield business procedures. He said the state's file of persons eligible under the program should be improved and he recommended that chiropractors be dropped from the program.

Registrations Going Well For MSMS Orient Trip in October

Registrations for the MSMS Orient trip immediately following the 1970 Annual Session are going extremely well, with 139 persons signed up as of April 20. A planeload for the Oct. 5-19 trip totals 165.

MSMS members and their wives who take the group tour will spend seven days in Japan and seven days in Hong Kong, with transportation aboard a 707 jet, oriental hosts, sightseeing tours, gourmet dinners at top restaurants and deluxe hotels in each city. Price is $898 per individual, including air fare, hotels, tips, meals, hosts and a complimentary cocktail party.

Martha Griffiths to Address May 12-14 Medical Staff-Trustee-Administrator Forum

U.S. Rep. Martha Griffiths (D-Detroit) will address the Fourth Annual Medical Staff-Trustee-Administrator Forum at Boyne Mountain Lodge May 14. She will discuss "Health Care Plans in the Seventies."

Theme of the forum May 12-14 will be "Working Together." It is held each year by the Michigan Hospital Association, in cooperation with MSMS, the Michigan Association of Osteopathic Physicians and Surgeons and the Michigan Osteopathic Hospital Association.

Two State-wide Programs Planned On Critical Health Problems During May

Two major programs on critical health problems are planned during May by the Michigan Health Council, in cooperation with MSMS and the Michigan Education Association.

Designed to give a major boost to grass-roots support of the Critical Health Problems Education Act of 1969, the two programs will be held May 15 at Lake Superior State College, Sault Ste. Marie, and May 21, at the Civic Center in Lansing.

The Lansing program, an all-day affair highlighted with an address by Gov. William Milliken, will also be the major state-wide activity of Education Day during the 1970 Michigan Week.

The two programs will constitute the 1970 version of the Michigan Health Council's annual Health Congress.

Michigan Pathologists' Flint Meeting May 9

The May 9 meeting of the Michigan Society of Pathologists at Hurley Hospital, Flint, will feature a seminar on major drug reaction pattern categories as they occur in various organs and tissues, and the methodology in evaluating drug reactions.

Speaker will be Col. N. S. Irey, MCUSA (Ret.), registrar of tissue reactions to drugs, Armed Forces Institute of Pathology, and clinical professor of pathology of George Washington University School of Medicine. The Pathologists' Society has invited science writers of the local public news media to attend the seminar.

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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

IN THIS ISSUE

The artwork on this month's cover comes from the AMA and is designed to promote Michigan Hospital Week May 10-16. A series of special articles inside the issue takes up subjects of interest to Michigan hospitals and physicians, in commemoration of the week declared by Gov. William Milliken.

SPECIAL MICHIGAN WEEK ARTICLES APPEAR ON BLUE PAGES 390-396, INCLUSIVE

SCIENTIFIC ARTICLES

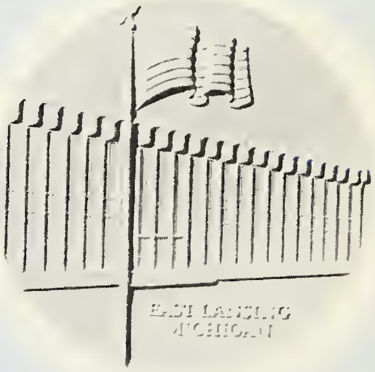
397 Community Referrals to a University Psychiatric Outpatient Clinic; David L. Neal, MSW, and Wiecher H. Van Houten, M.D., Ph.D.
403 Aids to Cardiac Diagnosis From Examination of the Cervical Veins; Noble O. Fowler, M.D.

SPECIAL ARTICLES

385 Hospital Costs and the Role of the Physician; John B. Sherman, M.D.
387 MSMS and the Michigan Hospital Association Work Together; Julien Priver, M.D.
389 The Human Side: Hospitals and Credit; Hugh W. Brenneman
402 Re-registration Figures Released
427 MSMS Council Helps Develop Assistant Physicians

OTHER FEATURES

375 breaking news
382 leadership
383 officers' page
406 monthly surveillance report
410 michigan mediscene
msms council minutes
414 editorial viewpoints
422 mailbag
425 medical care programs
427 michigan authors
434 county societies
439 about doctors
452 in memoriam
458 noted and quoted



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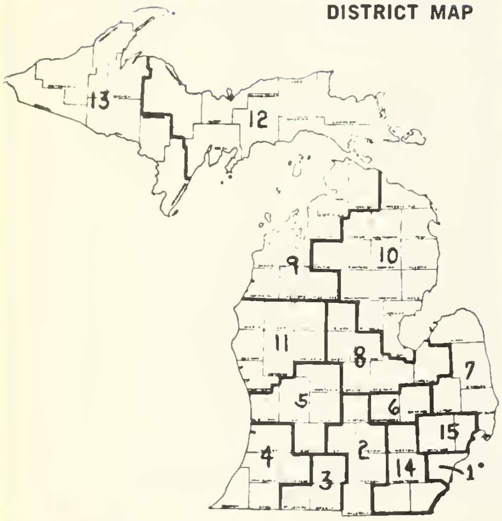

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Responsible Family Planning And Sex Education Necessary

In our visit together in the December issue of *Michigan Medicine,* we discussed the need for the medical profession to clarify its thinking on the many social problems facing us today.

One of those issues is family planning.

I was pleased to read the recent testimony by Gerald D. Dorman, M.D., president of the AMA, before a Senate committee considering S. 2108-Family Planning and Population Research Act. It is good to know that the AMA is standing tall on such public issues of family planning, sex education and population control.

Doctor Dorman reported that, "The AMA shares the concern of President Nixon and endorses the concept of a Presidential Commission on Population Growth and the American Future." He went on to contend, that "the AMA, however, believes that the problems of population growth call for additional steps, and therefore the AMA supports S. 2108."

S. 2108, as you may know, would amend and expand the family planning services and population research activities of the federal government. The bill, among other provisions, would establish a National Center for Population and Family Planning within HEW.

MANY PHYSICIANS, like me, are pleased to see the AMA vigorously supporting forward-moving positions and we hope that the news media will recognize the news in such statements. May I urge my fellow Michigan physicians to tell their congressmen, their associates, and persons especially concerned with social issues, to support S. 2108 and to study all other bills in such vital areas of concern.

Doctor Dorman made it crystal clear in his testimony that the AMA "strongly supports responsible sex education for young people." He described the AMA and physician efforts in promoting "responsible parenthood."

As a pediatrician, I know that family planning and responsible sex education are necessary because in our nation today, one sixth of all brides are pregnant on their wedding day . . . one out of every three high school brides is pregnant when she marries . . . one-half to three-fourths of the boys who marry while in high school are involved in premarital pregnancies . . . approximately one-half of the teen-age marriages end in divorce . . . etc.

THE NEED is urgent for research and new programs in the related areas of family planning, sex education, and population control by the public and private sectors — by physicians, the clergy, sociologists, social workers, public health personnel, teachers, economists and politicians.

Robt. J. Mason, M.D.
MSMS President

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Today practicing physicians are being buffeted on all sides by government, insurance carriers, purchasers of services, news media, etc. The following article has a great deal of food for thought and should be read by all physicians with considerable reflection on the views presented. Clinical physicians must battle these problems with a realistic viewpoint and the total picture in mind.

Hospital Costs And the Role of the Physician

BY JOHN B. SHERMAN, M.D.
LANSING

Some part of the high cost of hospital care is undoubtedly the responsibility of hospital physicians. By a process of constant reiteration, the easy transition has been made toward accusing physicians of being responsible for most of the costs of hospital care. The denial of this receives relatively little publicity.

Latest estimates from the House Ways and Means Committee predict a 14% increase in hospital costs in the coming year (1970), 13% in 1971, and then a gradually lower increase down to a steady 4% after 1977.

Hospital costs have been increasing at a greater rate than the rise in the general cost of living. In some measure this has been due to the time lag in bringing personnel salaries and wages into line with those obtained in other service industries. It can be expected to level off in the near future. Increases in the cost of hospital care will always be affected by external factors in the nature of social economic changes.

The cost of anything, goods and services, by itself has little significance. Costs must be related to the value received for the outlay. "What are we getting in return?" becomes just as important as, "What does it cost?" In the health field the former question may well be the more important. It is certainly a much more difficult question to answer. Whatever the cost, however, if full value for money is received there can be little cause for complaint. It is a "good buy."

The consumer, when he becomes an actual consumer, expects a high value care, in fact the "best possible service." This cannot be purchased except at a relatively higher cost.

The responsibility for providing full value for the costs of hospital care rests mostly with the physician. He can directly control value to a much greater extent than he can the costs.

Value in the hospital service means quality of care. Quality is a concept of many aspects, both subjective and objective. Amongst the latter is the fact that high quality care is efficiently, economically, and effectively rendered. These aspects are in large degree measurable. How then can the physician effect changes in the value of hospital care? The purpose of this paper is to discuss some specific measures.

ADMISSIONS

The decision as to whether a person is to be admitted as a patient in a hospital is solely the province of the physician. There is only one valid reason for admission, and that is medical necessity. Although study by physicians of all hospital admissions is advisable, certain patterns deserve closer study.

So-called "under 48 hour" admissions (actually those staying less than 48 hours) are worthy of study. The shorter the stay in a hospital, the more need there is to establish medical necessity. Such studies have revealed at times an inversely proportional relationship between these admissions and bed occupancy rates. They tend to occur less often when there is a shortage of beds and vice-versa.

Admissions who stay within the three-to-five range of days include the Medicare patients who need to establish eligibility for extended care. The number admitted solely to establish this eligibility

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The author is with the bureau of Medical Care Administration, Michigan Department of Public Health.

should be investigated. Some discussion has revolved around the question of whether the law should be amended to allow extended care eligibility to be established from out-patient service.

A number of admissions are "convenience admissions," that is, for the mere convenience of the patient or the family or even the physician himself. Possibly a relationship may be shown with bed occupancy rates here also. Some admissions occur for the sole purpose of investigation. Much of such work can be done by the use of less costly ambulatory services where these are available.

In general it is true that much of present misuse of hospital in-patient services is due to the lack of alternative and less costly means. Physicians have an important role in helping communities to supply such alternate services.

In hospitals with high occupancy rates, considerable care is given to the medical necessity of admissions. Conversely, where these rates are low (and the average rate over the State is 82%) there tends to be less inducement to establish the necessity. In these cases consideration might well be given to reducing the number of operative beds. Nonoperative beds cost but little to maintain.. Staff can be reassigned, or even reduced. The resulting economy can be considerable.

LENGTH OF STAY

It has been stated many times that if every hospital patient stayed one day less, a saving of many millions of dollars would be effected. The actual operating costs to a hospital are higher in the first few days of a patient's care. The last few days are less costly. If operative costs are averaged out on a per patient per day basis, then lowering the stay by one day will increase the daily average operating cost. This seeming paradox is resolved on the basis of the fact that the total health cost will be less. It must not be forgotten also that many patients upon discharge will still need care of some other kind, even though it will be less costly. Bed occupancy rates influence length of stay. The alternatives to unduly high rates are to shorten length of stay or to build more beds. To avoid building more beds, other services and facilities must be available in order that length of stay may be shortened without harm to the patient.

UNNECESSARY SERVICES

The decision as to which services a patient needs is solely that of the physician. The range of services which any one hospital provides should be based logically upon medical needs, and upon the ability to keep the service economically occupied. Unfortunately, in far too many hospitals logic is not a value. Hence there exists duplication of services within small areas, and costly services relatively little used, or misused in order to try to justify their existence.

Much thought and discussion relates to franchising of hospital construction. What is really needed is a franchising of services provided in hospitals. It is a sad commentary on our society that the ever-increasing risk of court actions almost compels physicians to overuse services, without really increasing quality of care.

THE TIME FACTOR

Loss of time and waste of time are sources of inefficiency and ineffectiveness. The misuse of a few minutes of time appears insignificant until it is multiplied thousands of times over.

Studies of the time lag in obtaining X-ray and laboratory reports, or in receiving consultation reports, can be quite revealing.

A considerable amount of time is spent by physicians and nurses in carrying out functions which could be performed well by lesser trained and less costly personnel. "Turnover time" relevant to bed utilization is worth studying. Consideration should also be given to waste of patient time especially in out-patient departments. Perhaps a better system of organization could avert this.

USE OF ANCILLARY PERSONNEL

An honest assessment should be made as to where and how and to what extent other disciplines can aid the professional staff. This involves not only the matter of saving time, but also the provision of more coordination of a total range of various services that increase the overall quality of the care rendered.

The ratio of hospital personnel to patients tends to increase. This increase can only be justified on a basis of real need. If it comes about because of lesser output per man of the present personnel, then the remedy lies not in the increase of those personnel.

Personnel are not the concern of physicians alone, but this part of the discussion raises an important principle; namely, that mutual assistance between physicians and administrative staffs is more than just highly desirable.

COMBINED STAFF COMMITTEES

Much time is spent by hospital physicians on medical staff committees. One suggestion worth consideration is to combine some of the duties. The Utilization Review Committee for example could well include the functions of medical audit, tissue review, and infection control. These four functions relate directly to patient care.

AREA WIDE HEALTH PLANNING

The inherent problems of comprehensive health planning are compounded by the fact that the few persons who know what comprehensive health really means, know little about planning. The experts in planning know little about comprehensive health.

No hospital can exist today in a state of isolation. What goes on outside the hospital influences the facility itself. Hence physicians have an obligation to take an active part in areawide planning. It can contribute considerably to the greater effectiveness of their hospital.

UTILIZATION REVIEW

Too often, review is but an example of the misutilization of time, paper, and effort which it is designed to avoid. Unless the committee can provide evidence that its efforts do actually influence effective utilization for the better, then such efforts are merely an exercise in futility. There is too often a failure to recognize the valuable potential of utilization review to increase hospital effectiveness. Almost all the methods discussed in this paper come within the purview of the Utilization Review Committee.

The contributions that can be made by the methods discussed here are apt to be small in themselves. Their combined effect can be considerable. The key to insuring that the quality or value of hospital service bears a proper relation to its cost is action, based upon knowledge of what is really happening within and without the hospital.

There's Much to Do for Private Sector; MSMS and MHA Working Together

BY JULIEN PRIVER, M.D.
PRESIDENT-ELECT
MICHIGAN HOSPITAL ASSOCIATION

We are witnessing a move by the courts toward a new doctrine of far-reaching hospital responsibility for both the quantity and quality of hospital care.

As a result we recognize the growing partnership between the medical profession and the hospital field in the provision of health services to our community.

ONE CANNOT OVER-EMPHASIZE the importance of the hospital in contemporary American society. It has become the central institution in the organization and delivery of health services, vital both to the care of the patient and to the practice of medicine.

At the same time both groups are under attack by the public which is virtually obsessed by the occasional lapse from their customary exemplary behavior. Dramatically rising costs; shortage of manpower; duplication of costly services and equipment; rapid obsolescence of sophisticated electronic devices; still undeveloped patterns for bringing the underprivileged into the "mainstream" of the health care system; all these have served to add fuel to the fire.

Both the Michigan State Medical Society and the Michigan Hospital Association have demonstrated their awareness of this situation by initiating a joint study of hospital and doctor efficiency. The spirit in which they entered into this collaborative venture bodes well for its eventual success. There is no attempt at vindictiveness. Rather one sees here a genuine desire to put forth a maximum effort for one basic objective — the best service for the consumer at the lowest possible cost.

One of the approaches will be the recognition of the age old maxim — "in union there is strength!" It is heartening to note how many hospitals and medical staffs in our state have begun to take steps to cooperate with fellow institutions and colleagues, even at the expense of "giving up" one service or another for the common good. Add this to the growing list of shared services already well established — such as computers; laundries; purchasing and other "non-medical" procedures — and we can begin to see the light at the end of the tunnel.

THE MOST STAGGERING PROBLEM facing our so-called "labor intensive" industry is how to overcome the "provider insufficiency." The push for more physicians is on, to be sure. But it will scarcely keep pace with population growth in the next decade.

A clue to the solution to this gross deficit may become evident from a statement by Dean Darrel J. Mase of the College of Health Related Professions, University of Florida: "We should all remember that in 1900 there was one supportive person for each physician; today the ratio is 13:1. By 1975 it is anticipated the ratio will be 20 or 25:1. These are currently divided into approximately 40 occupational categories representing 200 health careers."

I submit that the answer lies, therefore, in the immediate mobilization of our educational resources to provide the necessary curricula in our community colleges whereby we may offer exciting careers to our youth and middle-aged employables, while furnishing the physician captain of the team with the legions of specialized and skilled personnel he is scarcely aware of today.

There are many who feel that time is running out in the voluntary system. Daily the existing body of regulations governing all aspects of hospital operations grows larger. This runs the gamut from the organization and responsibilities of the medical staff; to methods of cost-finding and accounting; to the overtime pay and union rights of the orderly.

I agree with Anne Ramsay Somers of Princeton University, however, when she states that despite this extensive body of regulations, hospitals have, thus far, come off rather well. There is considerable legal tolerance and "administrative gentleness," due perhaps to "the persistent medical mystique, the inherent reluctance of laymen to interfere with matters even remotely connected with the practice of medicine; the feeling that hospitals are, by and large, run by dedicated people who are doing the best they can under very difficult circumstances; the absence of overt profit-making; the general presence — until very recently — of deficit financing; fear of alienating wealthy donors, and the belief that the voluntary hospitals were serving an essential public function which would otherwise have to be provided through public funds."

CERTAIN STEPS SEEM INDICATED for the future, which will continue to allow the private sector to function. There must be guarantees of quality control, which will go beyond the current minimum standards of accrediting bodies. Furthermore, there must be adherence to the principle that major planning for new construction should be controlled and regulated, with reasonable latitude and provision for an appeal mechanism for the aggrieved. Rate-setting by states should be discouraged — except possibly on experimental bases. Incentive reimbursement plans should continue to be sought and implemented, to supersede the ineffective open-end cost reimbursement method of today.

There is much to be done. I am confident that we have the will and the resourcefulness to accomplish what we set out to do. We need only to work together to define and agree upon our objectives. It is by so doing that the faith of the consumer — our fellow citizen — whom we are jointly pledged to serve, will be sustained.

I am grateful for this opportunity, on behalf of the Michigan Hospital Association, to express my personal thoughts and feelings about our mutual problems. I pledge the Association's continuing co-operation in our efforts to reach the common goal.

The MSMS delegates to the AMA House of Delegates have urged that a portion of the Himler Report discussing federal health programs "should be widely publicized to the profession."

The Himler report, in part, states, "it is safe to say that unless the private sector can propose effective solutions to existing problems, the next decade will see us moving in the direction of vastly broadened assumption of authority and responsibility by government, with a concomitant increase in public dependence on assistance programs."

The report goes on: "Ironically, the organization necessary to satisfy the newly aroused public impatience for better living conditions, more government guarantees, and greater security is almost totally lacking. Most federal government programs of recent vintage, since they were created in response to pressure or crisis, were hastily enacted with insufficient regard for their cost or their feasibility in terms of facilities, administrative mechanisms, and professional manpower. In addition, partly because differences in local conditions, needs, and facilities dictated that planning begin on a local level, partly out of deference to states' rights, and partly because central administration of massive new programs was not immediately practical, recent social welfare laws have been limited by Congress to the provision of grants-in-aid or matching funds.

"Implementation of the programs has been left to the states within fairly loose frameworks of conditions, standards, and criteria. Usually, to stimulate the states into prompt compliance, the laws set time limitations on program activation."

"Most states, anxious not to lose their share of federal largesse, passed hasty, and often ill-conceived, implementing legislation and then placed their reliance on local and municipal governments to put the programs into operation. The resulting confusion has seriously impaired the new programs and has brought about frictions and damaging waste of limited human and financial resources.

"In the general confusion, state and local legislators, administrators, and a new corps of government advisors have busily elaborated a great variety of favorite theories, plans and procedures, which, when translated into action, have proved to be costly and ineffective."

The Human Side:

Hospitals and Credit

(Editor's Note: Occasionally MICHIGAN MEDICINE will carry one of the many "The Human Side" articles written for daily and weekly news papers by Hugh W. Brenneman, MSMS executive director. Following is one of the columns which will interest physicians, their wives, the medical assistants, and others. Your reactions are invited.)

BY HUGH W. BRENNEMAN
EXECUTIVE DIRECTOR
MICHIGAN STATE MEDICAL SOCIETY

Hospitals never cease to amaze me. A hospital is a place where important things happen practically every day. It is a place where people who are sick and in trouble are sent to get help. It is a place where doctors strive to diagnose, to cure, and to console with the aid of nurses and other trained workers.

In many thousands of good hospitals the key concern is with the patients. Other hospitals concern themselves about tomorrow's patients. In these latter centers, teachers prepare young people for the health professions and many kinds of doctors and scientists engage in "the restless pursuit of excellence in care of the sick." They constantly reach out for more effective ways to prevent suffering.

OBVIOUSLY ALL HOSPITALS are not equal and neither is the kind of medicine practiced within them. Consequently, it is important to become acquainted with your own hospital in your own community and understand its problems, its costs, its limitations, and its potential.

Perhaps it is equally important to understand the great changes in hospital use that have come about during the past several years as well as the unusual number of related facilities that are not a hospital, but which carry out some of its functions . . . nursing homes, medical clinics, emergency facilities, homes for aged, etc. The trend of the hospital itself is toward providing more and better facilities to meet the demands of technological advances in care. These advances help not only those categories of conditions which have been treated in the past but those for which treatment has been previously considered hopeless.

All of these things are reflected in the cost involved. Those costs seem to continuously rise faster than the general trend of prices. In the east and many portions of the west, a basic semi-private room rate today for a hospital is $55 and in some of the medical centers, charges run as high as $70 to $74.50 a day for multiple-bedrooms.

HOSPITALS ARE BIG BUSINESS TODAY if the use of credit is accepted as a criterion. Neither the total of department stores' charge accounts nor the total credit used by any single commercial industry equals the amount of credit granted by hospitals, even though they might have greater income, spend more money or hire more people. When a patient presents himself at a hospital, he is granted higher credit than he's likely to get anywhere else in his community. His high credit at local stores might be $50 or $75, at local loan companies perhaps $300 with co-signers. But he could easily run up a $600 or $700 bill at a hospital and if he hasn't paid in advance, he has run that bill on credit. Over 70% of department store items are bought for cash. Yet 90% of hospital income is put on the books and paid later. Hospitals also grant credit to a large number of people who can't get anything on credit anywhere in the community!

It has been said that most hospital admittances are covered by insurance today. But when an insurance company is involved, credit is still granted; for by admitting the patient the hospital presumes that the policy is in force, that the patient will complete the insurance company questionnaire and other requirements, and that the patient's condition is covered by the policy.

It follows then that those of us who use the hospitals shouldn't object too strenuously when the admittance desk requires what seems to be an unconscionable amount of information. Just by asking the questions, they make people realize the hospital knows much about them; means to collect; and that the answers to those questions will be their tools for collection. Collections are important not only for the operation of the hospital but to increase the amount of funds that are available for charity care and for the education and training that the hospital can and must do. A true observation made before the turn of the century is:

> "Gratitude of patient is a permanent symptom only during height of illness."

Anesthesiology at the Crossroads—1970

BY THOMAS J. DeKORNFELD, M.D.
PRESIDENT
MICH. SOCIETY OF ANESTHESIOLOGISTS

Like much of American medicine, Anesthesiology is at the cross roads and the future of this specialty during the seventies depends upon making the right choice of route to follow.

The rapidly increasing demands for physician anesthesiologists and the very slow increase in the number of qualified physicians entering this specialty has created an anomalous situation without precedent in American medicine. Less than half of the anesthetics administered in this country are given by trained anesthesiologists, while nurses or not specially trained physicians are responsible for the bulk of the remainder.

This situation is fraught with dangers. First, over half of the surgical or obstetrical patients are receiving less than ideal anesthesia care. Secondly, the qualified anesthesiologists are overwhelmed with career opportunities and do not have to compete very hard for hospital privileges, or patients. This in turns tends to lead to a certain degree of complacency and to a lack of a sense of urgency to improve the general status of the specialty. The relative unavailability of trained physician anesthesiologists in many parts of the country and of the state, forces our colleagues in surgery and medicine to do without our services and tends to lower the esteem in which we are held.

MICHIGAN WEEK SPECIAL

In commemoration of Michigan Week—1970, MICHIGAN MEDICINE presents on this and following pages the thoughts of the presidents of several leading Michigan specialty societies as they look into the new decade. They have written about the challenges of the future in each of their fields. Space did not allow articles by all Michigan specialty presidents to be published and those asked to contribute were chosen on the basis of large memberships. MICHIGAN MEDICINE invites spokesmen from any other interested Michigan specialty organizations to submit their thoughts in 600-700 words for publication in future issues of the journal.

THE QUESTION which arises immediately is this: what can be done to reverse this trend; how can the status of anesthesiology be elevated; what steps can be taken to assure the optimal anesthesia to the maximum number of patients?

Clearly, the most important single factor must be an increased recruitment into the ranks of trained anesthesiologists. This can be accomplished by active participation in undergraduate and post graduate medical education, by active participation in hospital, county and state organizational activities and by much more active participation in patient care outside the confines of the operating room.

The anesthesiologist is particularly well qualified in rendering the most valuable consultant services in inhalation therapy, respiratory care, intensive care unit management and, in general, in the care of the critically ill or injured patient.

BY PARTICIPATING in these activities, anesthesiologists will increase the esteem in which they are being held by their colleagues and by their patients. They must and will dispel the widely held and totally erroneous feeling that anesthesiology is an "eight-to-two" technician specialty and will never again be considered members of the "unknown specialty."

In addition, organized anesthesiology must rigidly police its own ranks. It must not tolerate compromises with ethical and responsible patient care and it must assume the leadership in regaining popular esteem for the medical profession at large by developing a markedly increased social consciousness and by reorienting the thrust of individual and collective activities away from the disastrous income orientation of the past and towards the one thing that holds the promise of the future for all of us: service to our fellow man.

The Internist Looks to the Challenges of the 70s

BY BERNARD J. GOLDMAN, M.D.F.A.C.P.
PRESIDENT
MICH. SOCIETY OF INTERNAL MEDICINE

In answer to your request, I am happy to present you with the following material:

Two of the main purposes of our society are (1) To coordinate the efforts and unite qualified internists in furthering the practice of internal medicine, and (2) To study the scientific, economic, social and political aspects of medicine in order to secure and maintain the best patient care and the highest standard of practice in internal medicine.

The internist today is faced with many changing problems of medical practice in his office, in his hospital, and in his relationship with third parties. Medical knowledge doubles every 7 to 10 years and he must keep up to date. Continuing internal medicine education is important.

WHAT SHOULD BE our minimum standards of excellence or the goal of near excellence that we all should have? How much reading must be done? How many meetings should we attend? How many courses should we take? Perhaps periodic self-assessment tests such as that given by the American College of Physicians would be a partial answer and provide a stimulus as well.

There is a demand for more and better service in the face of the increasing shortage of physicians. What role will the "assistant physician" play? Certainly paramedical personnel can be of great help to us if used wisely.

Quality control of the care rendered by the internist may be accomplished by peer review. The American Society of Internal Medicine's committee on quality evaluation defines quality as follows: "Quality medical care embodies a scientific approach to the establishment of a diagnosis and institution of appropriate therapy and management designed to satisfy the overall needs of the patient. It should be readily available, efficiently rendered, and properly documented."

Multiphasic screening is here. It is being performed by health departments, private corporations, etc. What are the ethical and legal responsibilities when the screening results of people either never, or not recently seen by the physician suddenly appear on his desk? What role will computers play in the field of diagnostic and perhaps therapeutic medicine? Will the careful face to face comprehensive history performed by the internist be replaced?

IN THE AREA of hospital practice problems we find a rapid change. There is an increase of hospital-based and/or hospital-managed or coordinated ambulatory diagnostic, treatment and long-term health care. There is also an increase in the number of full-time physicians in practice in the hospital. Many envision the hospital as the primary health center. A full-time chief of medicine usually arises because of staff demand, lack of time on the part of the private practitioner and his request for relief from hospital demands.

There is an ever-increasing power and influence of third parties. Problems with third parties have consumed much of our time and efforts. Proper utilization, equitable remuneration for the services of the internist, and the already referred-to peer review and quality control are some of the areas involved. Increased paper work and frustrations added to an already overburdened practitioner decrease the amount of time that can be devoted to the care of patients.

WE HAVE SOCIAL responsibilities which we share with all physicians. What is the answer to ghetto medicine and the unequal distribution of medical care in general? How about the increasing problem of drug abuse?

All of the above problems have been and are still being worked on in depth by the American Society of Internal Medicine on the national level. Regional meetings enable the various state societies of internal medicine to share the knowledge thus obtained and to apply it on the local level.

The internist is aware of the challenges of the 1970's and it is the intent of our society to assist him in meeting them in a manner that will continue to "maintain the best patient care and the highest standard of practice in internal medicine."

Obstetrics and Gynecology, 70's Style

BY RALPH S. STEFFE, M.D.
PRESIDENT-ELECT
MICHIGAN SOCIETY OF OBSTETRICS AND GYNECOLOGY

The 1970's greet those of us in the specialty of obstetrics and gynecology, with some of the greatest challenges we have ever faced. The medical, economic, and social problems are immense. Our opportunity to make a great contribution is here.

In the 1970's, we will continue to see many profound changes in the attitudes, and the approaches to the legal status of abortion, sterilization, and sex education. We must be ready with wise, honest advice and council to the individual. In addition, society and government need our help. A joint effort by all groups will be required.

WE ARE FACED with increasing demands for safer and more effective methods of contraception. Continuing research in this area is necessary.

There is a rapidly increasing demand for permanent sterilization in both the male and the female. This will necessitate some changes in our present policies.

The changing moral attitudes toward abortion, along with liberalized abortion laws, will place great demands on each of us and on our specialty. We will each have to come to grips with our own conscience and our own attitudes. We will have to meet the changing times.

We need to give serious and immediate attention to the increasing problems of young people. There is a rapidly growing number of young women who are illegitimately pregnant. The problems in this group are increasing at an alarming rate. The dangers from drugs are frightening and far reaching. We do not yet know how extensive the damage may be to the parents, the baby, and to future generations. Present evidence suggests there are severe changes and all of them are bad.

More effort is needed in the field of health education, especially as it pertains to sex, pregnancy, and drugs.

We are faced with an increasing shortage of clinic and hospital facilities. We are faced with an acute shortage of obstetricians and gynecologists along with the necessary support personnel. We will need to find better ways to more effectively utilize our limited manpower and facilities. It will require a high degree of cooperation and dedication on the part of everyone. Careful study and accurate planning are essential to meet the increasing needs.

THE RUBELLA PROBLEM must be diligently pursued. It is reassuring to note that we now have the necessary knowledge and materials to eliminate Rubella with its dreaded fetal damage.

Our specialty of obstetrics and gynecology and we as individuals must meet the challenges of the 1970's. We cannot be passive observers. We must become involved. It may be later than we think.

Michigan Ophthalmological Society Looks Ahead

BY JOHN W. HENDERSON, M.D.
PRESIDENT
MICH. OPHTHALMOLOGICAL SOCIETY

In 1967 the Michigan Ophthalmological Society was established as a successor to the previous longstanding organization — the Detroit Ophthalmological Society. It was felt that those practicing ophthalmology throughout the state of Michigan would benefit by a statewide organization which would be more responsive to their needs. The first president of the newly named organization was Edmond L. Cooper, M.D., of Detroit.

Its current membership of 227 represents a sizeable proportion of the approximately 311 eligible individuals. The format of a regular meeting, held each month from November through April, has been followed and an outstanding series of speakers in clinical ophthalmology have brought current views in many important subject areas.

BEGINNING IN 1969 a Summer Conference was established which was held at Boyne Highlands, July 31 through August 2, with Frank B. Walsh, M.D., of Baltimore and Joseph Dixon, M.D., of Birmingham, Alabama as guest speakers, with an additional series of outstanding presentations by members of the Society.

It is contemplated that this will be an annual function to which all interested ophthalmologists are invited and plans are underway for the 1970 meeting, also to be held at Boyne Highlands July 10 and 11. Guest speakers this year will be David G. Cogan, M.D., of Harvard University and David Schoch, M.D., of Northwestern University. A summer meeting serves the purpose of allowing outstate members of the Society to take an active part and efforts have also been made to hold one of the regular meetings in an outstate location rather than in Detroit.

In addition, the Michigan Ophthalmological Society co-sponsored the meeting of the Ophthalmology Section of the Michigan State Medical Society at its 1969 meeting in Detroit. It is hoped that this relationship can continue in the future.

Each spring the Michigan Ophthalmological Society is invited to a special evening meeting of the Postgraduate Course in Ophthalmology held at the University of Michigan at which time the annual Walter R. Parker Lectureship is given by one of the guest speakers of the course.

A second and important function of the society has been its concern with social issues in delivery of medical care to the public of the state of Michigan and in particular the relationship between ophthalmology and optometry in provision of care.

For the past several years members of the Legal Committee of the Michigan Ophthalmological Society have met on a regular basis with a similar committee of the Michigan Optometric Association in an honest attempt to define, discuss, and resolve mutual problems as well as conflicts of interest which affect the delivery of the best care possible to our citizens.

Progress has been made in several areas, including an attempt to establish guidelines for inter-referral, a more precise definition of each group's role in delivery of care and mutual concern with regard to adequate screening of the preschool child in order to discover problems of amblyopia and other ocular conditions which can only be remedied at an earlier age. This resulted in a preschool vision screening bill sponsored by both groups which was passed by the legislature and signed into law in the 1969 session. This requires that each child entering school after the fall of 1971 must have had a vision screening examination in order to qualify for admission.

In order to keep pace with the legislative activities, both at a state as well as national level, the society has obtained the services of a legislative representative to speak for the peculiar problems of ophthalmology in the legislative arena.

THE APPROPRIATE UTILIZATION of ancillary paramedical personnel in ophthalmology has been a source of concern for the Society, since even with an almost complete filling of the residency positions in this country there will still be too few ophthalmologists in the future. One of the results of the joint interprofessional committee of the Michigan Ophthalmological Society and the Michigan Optometric Association has been a clearer understanding of the role of the optometrist working in the same office with an ophthalmogist. This has been encouraged and more such associations are gradually being established, providing means of extending care to a larger number of the population without unnecessary inter-referral. The society is also interested in making sure that other paramedical personnel within an ophthalmologist's office be trained and used as completely as possible under the direction of the responsible physician.

Those members of Michigan State Medical Society who are practicing ophthalmology are encouraged to join the Michigan Ophthalmological Society. Information can be obtained by writing to the President-Elect, Dr. Arthur E. Schultz, 303 Abbott Road, East Lansing, Michigan 48823.

Orthopaedic Surgery—Looking Back to the 1970s

BY R. W. POMEROY, M.D.
PRESIDENT
MICHIGAN ORTHOPAEDIC SOCIETY

(Dr. Pomeroy "looks back" into the 1970s as he composes an imaginary letter dated Jan. 1, 1980, to a practicing orthopaedic surgeon who was a senior medical student of 1970.)

January 1, 1980
Lansing, Michigan

Dear Jim:

I am flattered by your recent letter of reminiscence and your prognostications into the 80's. I hope I am here to see them come true. Indeed, I do remember our evening sessions of a decade ago during your final days of medical school; your enthusiasm and aggressiveness; your dissatisfactions with the establishment or what we in our generation called the "status quo"; your eagerness to change this and the various approaches to change that were developing at the time.

Over the years changes have been made at an increasing tempo. The rate itself is not constant in the various fields. I remember John Platt's comment at the time that in little more than a single life span, travel speed had increased a hundredfold; control of energy a thousand times; computation speed a million times; and our speed of communication by a factor of ten million. The changes we accepted, but the rates were difficult to comprehend. Jim, you were born into a rapidly expanding world and universe and grew up with the concept. You and your generation are more easily accommodating your lives, not to just "change" of "today" and "tomorrow," but to the extreme rapidity of change. This is an important difference between ten years ago and today.

Perhaps the computer can now be of help in appreciating this. Its use is really just coming into a practical realm. Over the past decade it moved out of the area of expensive experimentation and research into a more economical, functional part of everyday life. Its rather routine use in hospitals today was basically a dream of but a decade ago.

MEDICAL AND SCIENTIFIC progress has continued in the same increasing crescendo. Cancer viruses have been identified and now vaccines for certain forms are developing, all in less than a decade. Remember, Polio was about 60 years from virus discovery to practical vaccine use; Rubella and its anomaly prophylaxis some 40 years and now certain cancer management has been reduced to less than a decade between discovery of the virus and a therapeutic measure—all representative of that tightening spiral and increasing tempo that I mentioned.

Specifically, in orthopaedics, total joint and even bone, artificial and natural, replacement is working out of the "limited use" stage to almost a routine procedure, even as the "cup," prosthetic head and intramedullary "nailing" in the 60's. Cultured bone or "glue" has rapidly increased in its use.

Yet, you are right. The greatest changes of the 70's have been cultural and socio-economic, seen in medicine by reflection on patient care specifically and medical care in general. For better or for worse, nationwide medical coverage is now with us, although not in the national insurance form as originally proposed in 1970.

IN OUR AREA of orthopaedics the marked improvement in the delivery of emergency care has been most gratifying to me. The "ambulance" and its crew of today is hardly recognizable compared with that of a decade ago. Again, speed, communication and transportation have made this possible. The practicality of organized fracture, paralytic and other specialty trauma centers could only have developed with communication and transportation improvement and the realization by the public and the physicians that the emergency room care of the 60's was antiquated indeed.

One of the greatest medical changes I have been aware of involves medical education and the way it is affecting the practice of medicine:

1. The increase in number of medical schools, initiated in the late 60's and the increased class size has resulted in more physicians. This has helped to keep pace with the pop-

ulation growth but has failed to do so.

2. Basic curricular change, with increased patient emphasis and the increased use of community hospitals as training areas under university guidance. The "Internship" has gone, being amalgamated into the 4th year of medical school curriculum or the first year of postgraduate training.
3. The synthesis of the practice of medicine with the elimination of the M.D.-D.O. conflicts.
4. Increasing attempts to base education on knowledge attained, rather than rate of training opens the field to the slower learning, perhaps underprivileged, individual.
5. Marked increase and better use of paramedical personnel in patient management, i.e., the physician's assistant and acceptance in specialty areas of such individuals as our orthopaedic assistant.

All of this seems to have helped to improve the quality and quantity of individual and group medical care. The cross fertilization of education between paramedical and physician training programs has been healthy to watch.

But I have rambled enough. Let's get together soon. I will be most interested in your current thoughts, specifically in relation to what you are now going to do with all of these new "advances." The changes of the 70's are now yours and ready for your utilization.

Best regards,
R. W. Pomeroy, M.D.

On Being a Pathologist ...In the 1970s

BY EDWIN M. KNIGHTS, JR., M.D.
PRESIDENT
MICHIGAN SOCIETY OF PATHOLOGISTS

What is a pathologist? A red-eyed, hunchbacked fugitive from clinical practice? A drop-out from a psychiatric residency? A frustrated surgeon who never could keep his knots tied? An intellectual snob who prefers research to the office? A guy who just couldn't decide between hematology, bacteriology, cytology, serology, blood banking, biochemistry or alchemy — and ended up trying a helping of each? Or a harried scholar, overburdened with administrative responsibilities?

No doubt the picture you conjure up of a pathologist depends upon a variety of past experiences — "pathologists I have known . . ." We pathologists aren't very sure ourselves — the only thing we *are* sure of is that we find ourselves in an ever-changing role in today's world of medicine.

THE CLASSICAL *anatomical* pathologists, typified by such great teachers as Virchow, MacCallum and Boyd are still with us — publishing their monthly articles on *Electron Microscopy of Thyroid Parafollicular Cells of Cows in Response to Experimental Hypercalcemia Induced by Vitamin D*. But there is, also, a new breed of pathologist — the *Clinical* pathologist, elbow deep in probability curves, control sera, computer equipment, meeting notices and memos from the hospital administrators requesting immediate replies to previous memos already deeply buried in a blizzard of paper.

The complexities of today's laboratory operations are staggering. The pathologist is called upon to

be an administrator one minute, a mechanic the next — he injects BSP in a patient and rushes to perform a frozen section, finishing just in time to catch the next conference or committee meeting. He is held personally accountable for any of several hundred thousand annual laboratory tests which are either slow in being reported, hemolyzed, or fail to support the clinical diagnosis. He is expected to provide limitless quantities of compatible, wholesome blood upon demand.

But most important, we believe, is that the pathologist is a physician — your personal representative and consultant in the laboratory area. In this capacity, he deserves your fullest support. He is your assurance that laboratory policies are promulgated to further the practice of better medicine.

There are many counterforces at work: idealistic individuals demand economies at the expense of quality of medical care; there are some who equate masses of extraneous data with the ultimate in good medicine; others believe a computer to be an overnight solution to all laboratory difficulties; and there are those who would shortsightedly stifle research and initiative by dictating restrictive policies. There are political opportunists who bandy vague promises of "free" laboratory and medical services to expedite their careers, and there are economic opportunists — large corporations who see laboratory ownership as the key to vast profits in the field of health services.

THE PATHOLOGIST is deeply involved in the attempt to adapt the deluge of technological advances to the advancement of medical care. He needs your guidance to select that which will be of most value in the clinical evaluation of the patient. He needs your active cooperation in assuring that our laboratories continue to provide you with the latest available procedures, properly controlled, reliably and economically performed.

Michigan Radiologists Enter a New Decade

BY ERNEST P. GRIFFIN, JR., M.D.
PRESIDENT
MICHIGAN RADIOLOGICAL SOCIETY

The radiologists of Michigan enter the new decade with definite plans and goals for our specialty. In fact, we have already initiated our first phase in uniting the physician specialists and allied groups into a well organized unit.

During the past several months, we have launched a new organization, "The Michigan Radiological Society" which is intended to be the vehicle for uniting all radiologists into a single society.

OUR PURPOSES are to advance the science of radiology and improve radiologic services to the public by means of the study of the socio-economic aspects of the practice of Radiology; the encouragement of improved educational facilities for radiologists; the establishment and maintenance of high medical and ethical standards in the practice of radiology and the promotion of good fellowship among its members. This new society is a chapter of the American College of Radiology and was formed to replace a number of regional units.

As all Michigan physicians are well aware, the geographic problems of a state-wide organization in Michigan are of paramount importance. Our attempt to solve this problem has resulted in the evolvement of a sub-chapter system with local area meetings and three yearly meetings of the entire society. At the present time, the primary headquarters of the society will be located in Detroit and serve the eastern one-half of the Lower Peninsula. A sub-chapter, known as the West Michigan Section, will serve the remaining portion of the Lower Peninsula. The other sub-chapter will be the Upper Peninsula Section and will serve that area.

In our first year of operation under this new plan, there will be three combined meetings of the entire Society. These meetings are the annual out-state meeting of the Michigan Radiological Society which is scheduled for Lansing, Michigan on May 7 of this year. Roscoe Miller, M.D. from the University of Indiana is our scheduled scientific speaker. The second meeting in the series will be the Second Annual Summer Session which will be held at Hidden Valley, Gaylord, Michigan on June 25 to June 28, 1970. The panel of speakers will include William Seaman, M.D., of Columbia University. The third scheduled meeting for this year will be held in conjunction with the Section of Radiology of the Michigan State Medical Society at the time of the annual meeting of that society. A scientific speaker for this session has not been selected at this time.

IN ORDER that we may achieve our purposes, we have established several classes of membership that include those individuals that are closely allied with us in the practice of radiology. These individuals are persons with special qualifications in fields associated with radiology. This will include radiation physicists and physicians in training in radiology and its allied fields.

With this type of an organization, it is our hope to amalgamate the Radiologists of Michigan into a group that will bring to fruition all the purposes that were stated in the opening paragraph.

COMMUNITY REFERRALS TO:

A University Psychiatric Outpatient Clinic

BY DAVID L. NEAL, MSW
WIECHER H. VAN HOUTEN, M.D., PH.D
ANN ARBOR

INTRODUCTION

In 1967 a study was made of the service provided by the Adult Outpatient Clinic of the Neuropsychiatric Institute, University of Michigan Medical Center, to those persons who had referred patients to the clinic. The primary purpose of the study was to review the outpatient clinic's procedures in handling referrals and in providing information to referral sources. An attempt was also made to learn why referrals were being made to the outpatient clinic and what expectations the referral sources had of the clinic.

For two years prior to the study the outpatient clinic staff had made major changes in the procedures in handling referrals. All requests for appointments were being taken by a professional staff member in an attempt to provide the referral source with immediate consultation. It was anticipated that this service would improve communication between the referral source and clinic and it would result in better referrals to the clinic. The patient would ultimately benefit from the referral source and clinic working together.

While the clinic accepts referrals from the entire state of Michigan, this study was limited to referrals from Washtenaw County where the University Medical Center is located. This was done because of the limitation of time and because patients from Washtenaw County account for 56.7 per cent of the referrals to the clinic. The study involved only those persons working in the community who made an actual contact with the clinic about a patient. Those persons in the community who do not use the clinic's services may have an entirely different perception of the clinic.

Before explaining the methods of this study, it is important to review how a referral to the clinic is handled. The process begins with the secretary obtaining basic information which is recorded on a contact sheet.[1] The contact sheet is then given to a member of the professional staff who explores with the person who is making the referral the patient's problem, the services which seem indicated, and the most appropriate resource. In some cases it is decided not to schedule a psychiatric evaluation in the clinic. When it is determined that the patient should be seen in the clinic, the staff member must decide on the urgency of the situation and on what plan should be made.

METHOD OF STUDY

A. Sample

A classification of those persons who had referred patients to the clinic had been developed

scientific papers

Mr. Neal is chief social worker and Doctor Van Houten is assistant chief for the Adult Outpatient Clinic of the Neuropsychiatric Institute at the University of Michigan Medical Center. Doctor Van Houten is also an assistant professor of psychiatry at the U of M.

[1] A "contact" sheet is filled out for every initial contact with the clinic and it contains certain basic information. The secretary records the method of the initial contact, the name of the patient, his address, telephone number, age, and registration number. When the patient does not call, the name of the person contacting the department, his address, telephone number, and relationship to the patient are also recorded. The staff member records information about the problem, what is expected from the clinic, other resources previously contacted, the emergency of the situation, the disposition made, and the date and place the contact was received. The contact sheet becomes a permanent part of the patient's record.

	Cases	Sample
Welfare Agencies	12 (12.2%)	3 (12.5%)
Law Enforcement Agencies	5 (5.1%)	1 (4.2%)
Mental Health Agencies	31 (31.6%)	8 (33.3%)
Outside Medical Sources	32 (32.7%)	8 (33.3%)
Outside Psychiatrists	18 (18.4%)	4 (16.7%)
Total	98	24

Fig. I — Source of Referral and Sample

by the administration and cases were recorded on the basis of this system. It included five major classifications: Mental Health Agencies, Outside[2] Medical Sources, Outside Psychiatrists, Welfare Agencies,[3] and Law Enforcement Agencies.

A six month period from October 15, 1965 through April 15, 1966 was selected for this study. There were 733 initial contacts during this period, of which 414 (56.7%) were from Washtenaw County. Outside referral sources accounted for 104 (25.1%) of the contacts. A total of 98 cases accounted for the 104 contacts. **Figure I** indicates the number of cases referred from each referral classification and the size of the sample used.

An arbitrary decision was made to study 25 per cent of the cases. Once this decision was made, the sample size for each classification was computed. The IBM cards representing each case which had been separated into each classification were shuffled and the sample was randomly drawn.

B. Source of Data

The data for the study were obtained from several sources. Once a case was selected, the contact sheet was reviewed. In cases where the patient had been seen in the clinic, the patient's record provided additional information about what contact had been made with the referral source after the psychiatric evaluation.

With this information known, interviews were arranged with the referral sources. The name of the patient to be discussed was given to the referral source at the time the interview was arranged. Most of the people interviewed had their record of the patient available to them for the interview.

A questionnaire was developed to conduct each interview. After the purpose of the study was discussed, the referral source was asked to review how he decided to refer the patient to the outpatient clinic and what his expectations were of the clinic. The actual service provided to the referral source was then reviewed. The source was asked to make some judgment about how helpful this service was to him and if he thought anything should have been handled differently. The service provided to the patient was also reviewed with the referral source making the same type of judgments about it. The patient's current adjustment and his contact with the referral source since the referral to the outpatient clinic was also discussed.

In conducting the interviews the interviewer allowed the referral source to respond to the questions freely and the source's responses were recorded. Usually some additional clarifying questions were asked about his responses. For example, if the source responded that he felt the service was helpful, he was asked how it was helpful and if he thought anything else might have been done.

Once the questionnaires were completed, they were reviewed by a psychiatrist, psychologist, and social worker. These three persons are staff members of NPI, but do not work in the outpatient clinic. They were asked to evaluate the service provided to the referral source by the clinic. Instructions to them ask that they place each case into one of three classifications: (1) "Most Helpful" (2) "Helpful" and (3) "Not Helpful." Those cases in which the evaluator judged everything possible was done for the referral source by the clinic were considered "Most Helpful." "Helpful" cases were those in which the evaluator judged the services provided to the referral source to be useful but felt something additional might have been done. Cases where the service to the referral source did not add to the source's knowledge in working with the patient were judged "Not Helpful." It should be realized that the evaluators did not have access to the case records and were not evaluating the content of the service provided. Their evaluations were based on how the case was handled by the outpatient clinic and what was done for the referral source.

C. Biases

Several aspects of the methodology introduce biases into the study. The sample selected includes only those persons in the community who have made referrals to the outpatient clinic. While this should have no effect on the service provided by the outpatient clinic, one would expect that this group might have a more positive view of the clinic than those who do not make referrals.

Those interviewed may have been influenced by the circumstance that a professional worker from the outpatient clinic made a personal visit to their office. They may have felt that it might jeopardize their future service to be too critical.

Another important factor was the interviewer's subjective perception of what the referral source was reporting. It was impossible to record all of what was reported. There was some selection made as to the essence and importance of comments made to the interviewer.

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[2] "Outside" refers to physicians who do not have an association with the University of Michigan Medical Center.

[3] "Welfare Agencies" includes all social agencies such as Family Service.

RESULTS

The interviews with the referral sources indicated that they were generally pleased with the service provided to them by the clinic. In 17 out of 24 cases the referral source thought that the clinic had been as helpful as it possibly could; in 4 cases they thought the clinic had been helpful, but that something more might have been done, and in only 3 cases or 12.5 per cent did the referral source think that the clinic had not been of any help. The evaluation by a social worker, a psychiatrist, and a psychologist tended to be slightly more critical of the outpatient clinic. The greatest shift was from the "Most Helpful" to the "Helpful" category rather than from the "Helpful" to the "Not Helpful" category. In averaging the three examiners' totals, they placed: 41.7 per cent of the cases in the "Most Helpful" category, 40.3 per cent in the "Helpful" category, and 18.1 per cent in the "Not Helpful" category.

The kind of service provided to the referral sources was tabulated. In five cases advice or information was provided by the person who took the referral call and the patient was not scheduled in the outpatient clinic. For the 19 cases scheduled, 11 written reports were sent and seven telephone contacts were made. In two cases there was both a written report and telephone contact. In three cases there was no contact with the referral source after the psychiatric evaluation. These were generally placed in the "Not Helpful" category.

Those interviewed were asked to indicate what they expected from the clinic at the time of the referral and what some of the factors are which determine their decision to refer to the outpatient clinic rather than another resource. The responses obtained are indicated in **Fig. 2.** Only one person mentioned a service from the clinic which entailed his continuing responsibility for the patient. This indicates that the large majority of referral sources expected the clinic to assume responsibility for the patient once an appointment had been scheduled.

Those interviewed indicated that they made referrals to the outpatient clinic primarily because the clinic has a lower fee than private psychiatrists, because of the image of the University Medical Center, and the location of the clinic. Except for referrals made because of the image of the University Medical Center, a referral might have been made to any other mental health clinic. It appears that the local community looks to the outpatient clinic to serve the function of a local mental health clinic.

	Responses	Per Cent
*Services		
A. Psychiatric Treatment	18	90
B. Psychiatric Evaluation	6	30
C. Hospitalization	5	25
D. Consultation	1	5
E. Emergency Service	1	5
*Factors Determining Referrals		
A. Lower Costs	5	25
B. Image of University Hospital	5	25
C. Location	2	10

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*Percentage computed on a basis of 20 individuals interviewed.

Fig. II — Reasons for Referral To the Outpatient Clinic

In making referrals to the outpatient clinic, 55 per cent of those interviewed indicated that they lacked some basic information which tended to hinder the referral process. These problems seemed to result because the clinic is a part of a large medical center where there are a number of complex and differing policies. Most of the problems were said to exist with all clinics in the medical center and in some cases the person being interviewed would start to discuss a problem with another clinic. Several of the physicians interviewed thought that their greatest asset was a secretary or nurse who had formerly worked in the medical center and who understood the procedures. Some of the problems mentioned were: not knowing the telephone number of the outpatient clinic so that they could make a referral, not knowing the fee policies, not knowing where to call for inpatient referrals, not knowing about registration procedures and not knowing scheduling procedures within the outpatient clinic. These problems all made it more difficult to make a referral to the outpatient clinic.

The other major problem area centered around not understanding how the outpatient clinic sees its function within the community. At one agency four supervisors sat in on my interview with note pads. All were interested in learning more about how the outpatient clinic functions. Most of those interviewed mentioned that they realized that the clinic has teaching responsibilities and must screen cases that are accepted for treatment. They would like to understand how cases are selected. This information is vital to them in making decisions about what cases to refer to the outpatient clinic.

DISCUSSION

The results indicate that the referral sources thought that the outpatient clinic had been helpful to them in most cases. Contrary to some expectations prior to the study, those interviewed were not severely critical of the service they received and they were basically very pleased with it. This includes situations where the referral source did not receive the service which they expected when making the referral. For example, someone may call to make a referral and it may be determined by the person taking the call that another resource would be more appropriate. In other cases the patient was evaluated and then referred back with some explanation about the patient and with some recommendations about what is needed. Persons making referrals to the clinic appear to be looking for someone to assume responsibility for the patient, but are willing to continue primary responsibility if some recommendations are given to them.

It is our philosophy that service begins to the referral source at the time the initial referral call is received. The relationship between the patient, referral source, and clinic should be established. Our staff views the clinic as a specialized faculty within the community's total resources.[4] Each patient and referral source brings many unanswered questions and expectations when requesting an appointment in a psychiatric clinic.[5] The more these are verbalized and explored at the time of the initial request for service, the more helpful the clinic can be to the referral source and patient.

The cases in which the referral sources thought that the clinic had not been helpful to them were those where an appointment had been scheduled, but they were not notified about the findings. Generally, the patient would return to them at a later date with the same problem. The referral source would have to depend on what the patient reported about what the clinic had recommended and they were frequently unsure about what to do or say. A decision would need to be made whether to contact the clinic to find out what had happened or to rely on the information from the patient. If the clinic was to be contacted for their recommendations, another appointment would generally have to be scheduled as it would take time to obtain this information. This created considerable expense for the referral source and patient. It seems that it is extremely important to notify the referral source about the psychiatric evaluation. This does not necessarily have to include psychiatric information or a diagnosis, but should include the recommendations that were made and whether the patient agreed to act on them.

The referral sources were primarily concerned about a lack of pertinent information available to them about the outpatient clinic. Several persons did not know the telephone number of the outpatient clinic; others did not know the fees charged, and some did not know where the clinic was located. They frequently relied on information given by a telephone operator of the University or hearsay information. These messages were often conflicting and it made the referrals more difficult. This seemed to result because the clinic is a part of a large medical center with many different policies and procedures. The physicians interviewed indicated that this was a general problem for all of the clinics in the medical center, but it is an important problem for psychiatric patients who are frequently anxious and ambivalent about seeing a psychiatrist. The psychiatric clinics associated with medical centers, whether they are medical schools or general hospitals, need to assume responsibility for making this general information about their policies and procedures available to the community.

Everyone interviewed indicated that they understood that the outpatient clinic had certain teaching responsibilities which affected the kind of service a patient would receive, although they did not know in what way. They would prefer to have some notion of how treatment cases are selected feeling that this information would be useful to them in deciding on appropriate referrals to the clinic. Even though many of the factors which determine whether a case will be selected for treatment are very subtle, some broad explanations could be given. It seems that this situation is not unique to teaching centers. All mental health clinics which offer treatment must make some selection of the cases that will receive treatment and also the type of treatment they will receive. If clinics would make their policies more explicit, it would develop better relationships with referral sources and more appropriate referrals.

SUMMARY

The referral sources thought that the service provided to them by the outpatient clinic was helpful in almost 90 per cent of the cases. Those cases which were thought to be "Not Helpful" were those where the outpatient clinic failed to communicate to the referral source the results of the psychiatric examination. Most of the difficulties were the result of the referral sources lacking certain basic information about the outpatient clinic which is needed to make a good referral.

Most referral sources were looking for the outpatient clinic to assume primary responsibility for the patient. When the outpatient clinic was able to provide some information and advice to the referral source whether at the time of the initial request or after the psychiatric evaluation, they were willing to continue primary responsibility for the patient.

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[4] Herbert L. Rooney and Alan D. Miller, "A Mental Health Clinic Intake Policy Project—A Discussion of Philosophy, Goals, Techniques, and Results," *Mental Hygiene,* Vol. XXXIX, (July, 1955), p. 392.

[5] Ibid.

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The following statistics are taken from the Michigan State Board of Registration in Medicine Report on 1970 Re-registrations, as of March 20, 1970. Statistics for every 3rd year are printed to show changes. Copies of the yearly figures are available from MSMS.

NUMBER OF REGISTERED PHYSICIANS

COUNTY	1960 POP	1970	1967	1964	1961
Alcona	6,352	1	-0-	-0-	-0-
Alger	9,250	6	5	5	4
Allegan	57,729	26	30	32	26
Alpena	28,556	27	27	28	28
Antrim	10,373	2	5	5	3
Arenac	9,860	3	3	1	-0-
Baraga	7,151	6	4	3	1
Barry	31,738	18	17	16	18
Bay	107,042	85	91	92	89
Benzie	7,834	3	3	5	2
Berrien	149,865	121	114	114	108
Branch	34,903	26	29	28	24
Calhoun	138,858	137	146	138	129
Cass	36,932	9	12	12	11
Charlevoix	13,421	9	9	13	9
Cheboygan	14,550	9	8	7	7
Chippewa	32,655	21	22	16	19
Clare	11,647	5	6	4	5
Clinton	37,969	11	11	16	16
Crawford	4,971	8	7	5	5
Delta	34,298	21	24	26	21
Dickinson	23,917	27	28	30	21
Eaton	49,684	22	20	22	22
Emmet	15,904	48	37	33	27
Genesee	374,313	341	339	326	309
Gladwin	10,769	4	6	5	5
Gogebic	24,370	13	14	13	16
Gd. Traverse	33,490	86	76	72	77
Gratiot	37,012	27	22	24	22
Hillsdale	34,742	17	17	17	16
Houghton	35,654	26	24	21	23
Huron	34,006	22	21	19	18
Ingham	211,296	319	296	263	248
Ionia	43,132	22	22	27	25
Iosco	16,505	7	5	7	2
Iron	17,184	8	11	10	13
Isabella	35,348	32	29	24	26
Jackson	131,994	113	113	120	127
Kalamazoo	169,712	269	252	221	199
Kalkaska	4,382	3	3	2	1
Kent	363,187	482	449	454	427
Keweenaw	2,417	1	1	-0-	2
Lake	5,338	7	3	4	1
Lapeer	41,926	20	23	23	26
Leelanau	9,321	3	-0-	3	-0-
Lenawee	77,789	60	61	55	57
Livingston	38,233	26	26	27	22
Luce	7,827	9	13	14	14
Mackinac	10,853	4	5	7	8
Macomb	405,804	256	216	169	98
Manistee	19,042	16	14	14	14
Marquette	56,154	65	54	48	48
Mason	21,929	17	16	17	18
Mecosta	21,051	13	14	10	10
Menominee	24,685	10	12	13	16
Midland	51,450	67	56	50	42
Missaukee	6,784	3	2	2	3
Monroe	101,120	46	43	44	42
Montcalm	35,795	17	19	18	22
Montmorency	4,424	-0-	-0-	1	1
Muskegon	149,943	125	125	121	118
Newaygo	24,160	15	13	16	19
Oakland	690,259	1,217	906	777	486
Oceana	16,547	6	8	8	8
Ogemaw	9,680	6	8	7	6
Ontonagon	10,548	4	3	5	5
Osceola	13,595	6	4	4	5
Oscoda	3,447	3	1	2	1
Otsego	7,545	9	8	7	8
Ottawa	98,719	83	76	67	61
Presque Isle	13,117	4	1	1	1
Roscommon	7,200	6	6	5	4
Saginaw	190,752	188	170	168	153
Sanilac	32,314	17	17	15	16
Schoolcraft	8,953	5	5	5	4
Shiawassee	53,446	34	27	31	33
St. Clair	107,201	85	80	79	69
St. Joseph	42,332	29	28	32	35
Tuscola	43,305	17	16	19	18
Van Buren	48,395	31	30	30	29
Washtenaw	172,440	885	728	695	591
Wayne	2,666,297	2,882	3,121	3,136	3,155
Wexford	18,466	20	16	17	13
SUB TOTAL		8,759	8,332	8,043	7,431
OUT OF STATE		3,016	2,630	2,280	1,185
TOTALS		11,775	10,962	10,323	8,616
MILITARY (Exempt)		615	622	412	
FOREIGN (Missionaries, Peace Corp., etc.)		66			
GRAND TOTAL		12,489	11,584	10,735	8,616

LOCATION OF MICHIGAN PHYSICIANS

	MD Grand Totals	In Michigan	Out of Michigan	In Military	*In Foreign Countries
1970	12,489	8,759	3,016	615	99
1969	12,297	8,742	2,905	571	79
1968	11,830	8,379	2,786	665	—
1967	11,584	8,332	2,630	662	—
1966	11,292	8,307	2,514	471	—
1965	11,025	8,189	2,404	432	—
1964	10,735	8,043	2,280	412	—
1963	10,237	7,746	2,092	399	—
1962	10,133	7,714	2,142	277	—
1961	8,616	7,431	1,185	—	—

* With Missionaries, Peace Corps, etc.

From Examination of the Cervical Veins

Aids to Cardiac Diagnosis

BY NOBLE O. FOWLER, M.D.
CINCINNATI

METHOD OF INSPECTING THE JUGULAR VEINS

The patient should lie so that the thorax is elevated approximately 30 degrees from horizontal, employing a bed or examining table which breaks at the hips, so that the thorax, abdomen, head and neck are elevated, while the lower extremities remain horizontal. The veins are best seen with artificial light directed tangentially across them in order to produce shadows.

Order of procedure: The external jugular veins and the internal jugular veins should be identified bilaterally. In many patients the external jugular veins are invisible. Important information may be missed if the internal jugular veins are not examined. If pulsations are not visible in the internal jugular veins, with the patient's thorax elevated to 30 degrees, then the thorax should be raised or lowered.

The internal jugular veins lie deep to the sternomastoid muscles and are best recognized by their broad, undulating, and triphasic pulsations, (**Figure 1**). The *a* wave is produced by atrial systole. It is the quick wave which just precedes the carotid pulse. The descending limb of the *a* wave is followed by a negative wave, the *x* wave, produced by atrial diastole, (**Figure 2**). The *x* wave is followed by the second positive wave or *c* wave, (**Figure 1**). The *c* wave results from bulging of the tricuspid valve into the right atrium as the right ventricle begins to contract; however, in the neck veins the *c* wave is considerably augmented by the underlying carotid pulse. The third positive wave of the jugular pulse is the *v* wave, which is produced by passive filling of the right atrium, (**Figure 1**). The descent of the *v* wave is referred to as the *y* descent, (**Figure 2**), inscribed as the tricuspid valve opens and blood flows into the right atrium.

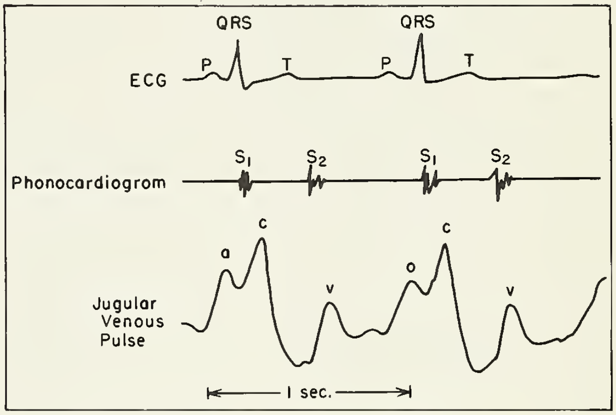


Figure 1. External recording of normal jugular venous pulse, demonstrating **a, c,** and **v** waves. For discussion, see text. From Fowler, N.O., **Cardiac Diagnosis.** Hoeber-Harper, 1968. By permission.

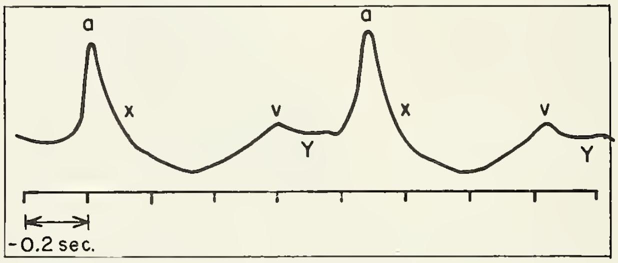


Figure 2. External recording of jugular venous pulse of a patient with tricuspid stenosis, showing large **a** wave and slow **y** descent. From Fowler, N.O., **Cardiac Diagnosis.** Hoeber-Harper, 1968. By permission.

When large *v* waves dominate the internal jugular pulse, as a result of right ventricular failure or tricuspid insufficiency, the venous pulse may be confused with the carotid pulse.

The following procedures will distinguish the two. Moderate pressure with a tongue blade or the edge of the hand will obliterate the jugular but not the carotid pulse. If the cervical venous pressure is increased because of right heart failure, abdominal pressure with the hand, sustained for thirty seconds or so, will usually cause the venous pulse to become larger and to ascend higher in the neck (hepato-jugular reflux).

With the Valsalva maneuver, the jugular veins

The author is with the Cardiac Research Laboratory, Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati. His article is another in the series on clinical cardiology prepared by the American Heart Association and made available to MICHIGAN MEDICINE by the Michigan Heart Association.

usually become more distended but lose their pulsations; not so the carotid arteries. Usually the jugular venous pulses descend lower in the neck during inspiration or when the patient's head is raised, but the carotid pulse is not so affected.

INFORMATION OBTAINED FROM EXAMINATION OF THE JUGULAR VEINS

1) *Estimation of the systemic venous pressure.* When internal or external pulsations are more than 2 or 3 centimeters above the manubrium, one may be confident of elevation of systemic venous pressure, usually from right ventricular failure or constrictive pericarditis. A positive hepato-jugular reflux confirms this observation. The patient must continue to breathe normally and must not perform a Valsalva maneuver during the test. Bilateral non-pulsatile distention of the jugular veins, associated with a collateral venous pattern over the upper chest, suggests superior vena caval obstruction from aortic aneurysm, lymphoma, thymoma, or bronchogenic carcinoma.

2) *Distention of only the left jugular veins.* This usually indicates obstruction of the left innominate vein (kinked left innominate vein). This most commonly results from an elongated aortic arch associated with hypertension or atherosclerosis. However, on occasion, the left innominate vein is compressed by an aneurysm involving the aortic arch.

3) Prominent *a* waves in the jugular venous pulse with each cardiac cycle suggests forceful right atrial systole, related either to tricuspid obstruction or increased thickness of the right ventricular wall (decreased compliance). The following clinical causes may be considered:

a) *Tricuspid stenosis.* Usually there is accompanying rheumatic mitral disease. The *a* wave may ascend in the neck during inspiration: normally it descends during inspiration. There are usually shallow and slow *x* and *y* descents (**Figure 2**).

b) *Congenital tricuspid atresia.*

c) *Right atrial myxoma.*

d) *Pulmonary valvular stenosis of moderate or or severe degree.* Prominent *a* waves are ordinarily not to be found in tetralogy of Fallot.

e) *Congenital pulmonary atresia with intact ventricular septum.*

f) *Pulmonary hypertension.* Mitral stenosis, lung disease, idiopathic or thromboembolic pulmonary hypertension, or pulmonary arterial branch stenosis may be the cause. Prominent *a* waves occasionally occur in Eisenmenger's syndrome.

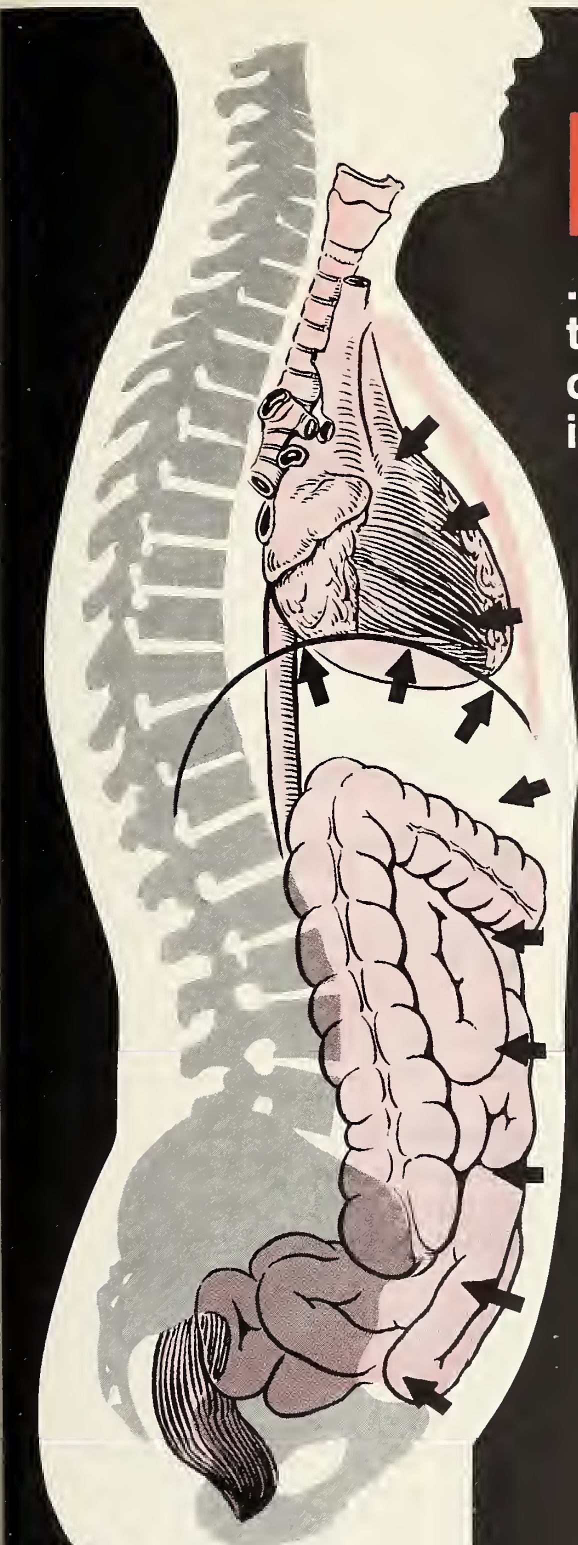
g) *First degree A-V block of sufficient degree that atrial systole occurs when the tricuspid valve is closed.* Similarly, large *a* waves may occur during A-V nodal rhythm.

4) *Irregular giant **a** waves or cannon **a** waves.* These may occur with premature atrial or ventricular systoles, if atrial systole coincides with ventricular systole. Irregular cannon *a* waves also may occur with a regular ventricular rhythm when there is atrioventricular dissociation resulting from complete A-V block, A-V dissociation by interference or paroxysmal ventricular tachycardia. With complete A-V block in adults, the ventricular rate is usually near 40 per minute and there is varying intensity of the first heart sound. With A-V dissociation by interference, the ventricular rate is usually between 60 and 110 per minute. With ventricular tachycardia, the ventricular rate is usually between 130 and 250 per minute. The atrial rate, as judged by the jugular *a* waves, is most often at the normal sinus rate of 60 to 100 per minute.

5) *Atrial flutter.* With this one may be able to detect small rapid regular oscillations which occur approximately 300 times per minute.

6) Prominent *c-v* waves, with obliteration of the *x* descent usually reflect tricuspid insufficiency. This sign is most pronounced in patients with rheumatic mitral disease and rheumatic tricuspid insufficiency; it may also occur with right heart failure.

7) *The y descent.* It is usually accentuated with constrictive pericarditis (diastolic collapse of Friedreich). Patients with constrictive pericarditis almost invariably display increased venous pressure. Some demonstrate increased jugular distention during inspiration (Kussmaul's sign). This sign may be positive in occasional patients with right ventricular failure, especially in those with restrictive myocardiopathy.



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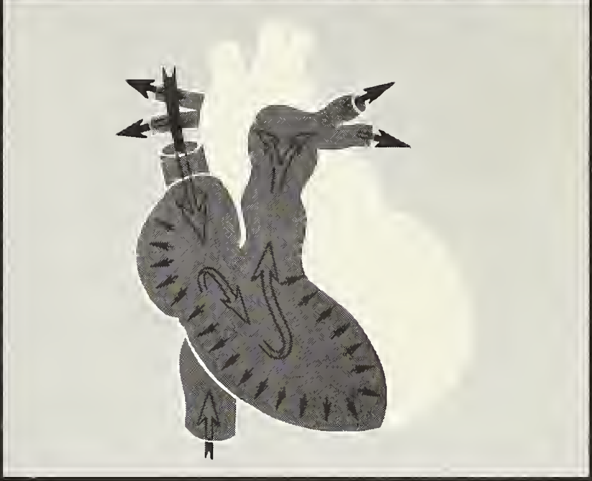

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*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice*, 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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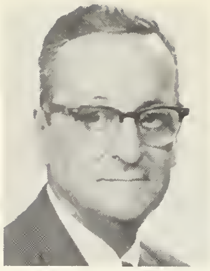
Doctor Reizen



Doctor Rice

Heartiest Greetings

The members of the Michigan State Medical Society jointly and severally congratulate Maurice Reizen, M.D., who was appointed Director of the Michigan Department of Health March 31, 1970 by Governor William Milliken.

We are fortunate in having Dr. Reizen in this high and sensitive public office. His performance in the private practice of medicine, in lesser public health positions and with the MSMS, as Chairman of both our Section, and our Committee, on Public Health has been uniformly superlative.

The challenge facing this talented medical executive is one worthy of his greatest effort. If he meaningfully blends the fine natural health resources and physical facilities of Michigan with the talent of its health professionals the result will protect our people and serve the nation as a model.

Heartiest Greetings, Dr. Reizen. Call on us to help you.

Hail, But Not Farewell

Gerald Rice has been Director of the Department of Health for 24 months. He left that post to return to his specialty area as Bureau Chief of Maternal and Child Health in the Department of Health.

We admire Dr. Rice. He stepped into a very tough job, which he had not sought, and carried out the mandate of his office in a most competent fashion.

His excellent work and his gracious sense of humor and modesty earned him the respect of his co-workers and his peers in public health, as well as in private practice.

But his physical being protested and in the resulting confrontation Dr. Rice was forced to compromise. He has done so and, fortunately, he can and will continue to serve his public and his profession in Michigan.

It is great to be able to say "Hail, for a job well done, but not farewell!" to our able friend.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

Monthly Surveillance Report

Cases of Certain Diseases Reported To the Michigan Department of Public Health For the Four-Week Period Ending March 28, 1970

	1970 THIS 4-WEEK PERIOD	1969 SAME 4-WEEK PERIOD	1970 TOTAL TO ABOVE DATE	1969 TOTAL SAME DATE	TOTAL CASES FOR 1969
Rubella	493	495	1109	963	4307
Measles	136	26	260	76	401
Whooping Cough	6	48	30	67	192
Diphtheria	—	—	—	—	—
Mumps	723	658	1862	1636	5215
Scarlet Fever & Strep Sore Throat	1366	1188	4079	3186	9763
Tetanus	—	—	1	1	6
Poliomyelitis (paralytic)	—	—	—	—	—
Hepatitis	354	267	1102	750	3360
Salmonellosis (Other than S. typhi)	25	35	116	102	539
Typhoid Fever (S. typhi)	—	—	1	—	6
Shigellosis	17	20	45	83	300
Aseptic Meningitis	5	10	16	28	179
Encephalitis	3	8	15	21	120
Meningococcic Meningitis	2	9	17	34	114
H. Influenza Meningitis	6	4	18	11	56
Tuberculosis	126	184	514	571	2108
Syphilis	288	326	888	1134	4021
Gonorrhea	1489	1316	5056	4253	19194

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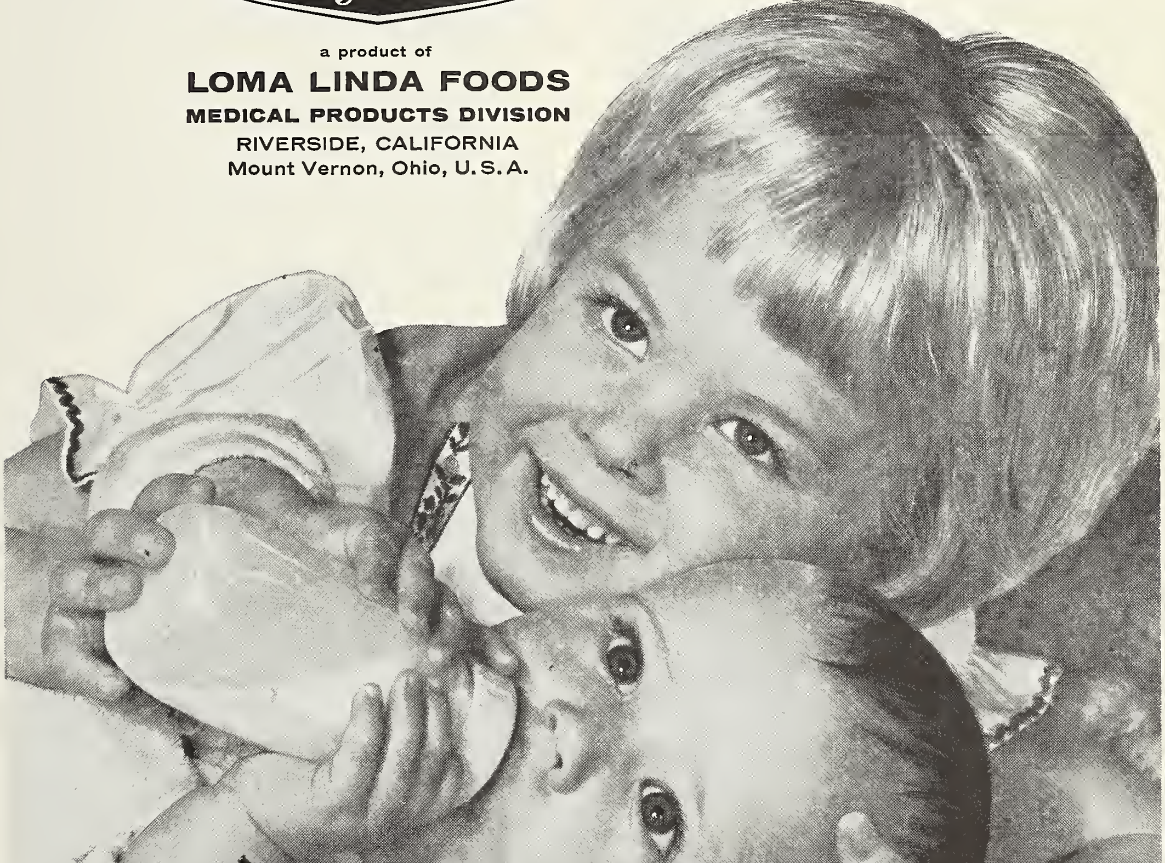

800,000 Michigan Children Vaccinated for Rubella; Physicians Important Factor

BY JUDITH MARR
MANAGING EDITOR

In Ingham County, members of the medical society voted to pay up to $2,500 of the expenses of the county health department in providing rubella vaccine to youngsters during the recent state-wide campaign.

In Washtenaw County, the medical society provided 16 volunteer physicians who staffed 60 school clinics where 13,000 of the county's 16,000 eligible children were immunized. In addition, the medical society arranged for the services of 15 resident physicians from the University of Michigan to help man the clinics.

The reactions of physicians in Ingham and Washtenaw Counties to the recently completed rubella immunization campaign across Michigan are typical of those by other county medical societies across the state.

In fact, the reaction of all physicians to requests for completing the campaign were so good, the director of the campaign was reluctant to single out any societies as especially good.

According to John L. Isbister, M.D., bureau chief of community health, Michigan Department of Public Health, which coordinated the campaign, "The response from the medical societies in alerting the public and their members to the campaign and in immunizing the children was wonderful."

The proportion of children immunized so far has run as high as 96 per cent in Saginaw City, 90.7 per cent in Mason County and 90 per cent in Muskegon. The percentage of children immunized across the state was approximately 85 per cent of those eligible, or an estimated 800,000 children. Only one county reported less than 70 per cent of its eligible children immunized.

Most counties had to buy additional vaccine, reports Doctor Isbister, and many counties scheduled make-up clinics which boosted the total of children vaccinated. In Ingham County, 3,000 additional doses were required, prompting the medical society to lend its support to the larger-than-anticipated bill.

Maurice S. Reizen, M.D., then county health director and newly-named director of the state health department, praised the Ingham society's action as another example of the community-minded concern of local doctors.

Brief Summary of Prescribing Information–9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet b.i.d.
Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

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Easy-to-live with cost of therapy. The one to two tablets a day maintenance dose makes Salutensin economical to stay with. Important, because long-term control calls for long-term therapy.

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msms news

Michigan Mediscene

May 6 – Michigan Cancer Coordinating Committee, MSMS Headquarters, East Lansing, noon.

May 6-8 – Michigan Public Health Association Annual Meeting, Statler-Hilton Hotel, Detroit.

May 7-9 – Michigan Heart Association Heart Days and Scientific Sessions, Cobo Hall, Detroit.

May 10-16 – Michigan Hospital Week.

May 12-14 – Medical Staff-Trustee-Administrator Forum, sponsored by Michigan Hospital Association, Boyne Mountain Lodge.

May 13-14 – Wayne State Medical Alumni Clinic Days, Cobo Hall, Detroit.

May 15-16 – Michigan State Association of Industrial Nurses Spring Conference, Holiday Inn, Midland.

May 16 – 15th Annual All-Day Scientific Session, Michigan Society of Anesthesiologists, Sheraton-Cadillac, Detroit.

May 16-23 – Michigan Week.

May 18 – MSMS Annual Conference on Medical Reporting, Kellogg Center, Michigan State University, East Lansing.

May 21-22 – MSMS Annual Maternal Health Conference, Kellogg Biological Station, Gull Lake.

May 23-24 – Ninth Annual Kidney Disease Symposium, sponsored by Kidney Foundation of Michigan, Towsley Center, The University of Michigan.

May 27 – MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

June 17 – MSMS Special Council Meeting, MSMS Headquarters, East Lansing, noon.

June 18-20 – Upper Peninsula Medical Society 75th Annual Meeting, Sault Ste. Marie.

June 21-25 – Many Michigan physicians will participate in the AMA Convention in Chicago.

July 23-25 – MSMS Midsummer Session of The Council, Grand Hotel, Mackinac Island.

July 30-31 – 50th Annual Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City.

Sept. 20 – MSMS Council, Sheraton-Cadillac Hotel, Detroit, 9:30 a.m.

Sept. 20-24 – MSMS Annual Session, Sheraton-Cadillac Hotel, Detroit.

Sept. 23 – MSMS Council, Sheraton-Cadillac Hotel, Detroit, 8 a.m.

Sept. 23-24 – Annual Convention of Woman's Auxiliary to MSMS.

Oct. 16-17 – Michigan State Association of Industrial Nurses Fall Conference, Holiday Inn, St. Joseph.

Nov. 4 – Special meeting of The Council, MSMS Headquarters, East Lansing, noon.

Nov. 11 – Michigan Cancer Coordinating Committee, MSMS Headquarters, East Lansing, noon.

Nov. 29-Dec. 2 – Many Michigan physicians will participate in the annual AMA Clinical Convention in Boston.

Dec. 9 – MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

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council minutes

Meeting of March 11, 1970

Council Acts On Pollution, Ass't. Physicians, Rubella

MEDICAL CHARGES — The Council authorized the chairman to inform Michigan Medical Service that MSMS urges all physicians to use their customary restraint in considering increases in charges for professional services, and to base any changes in charges on their own increased overhead.

DOCTOR'S SERVICE REPORT — The Council authorized its chairman to inform Michigan Medical Service that the new Doctor's Service Report form developed by MMS is highly objectionable.

NATIONAL HEALTH INSURANCE — The Council referred to the MSMS Committee on Planning and Priorities a recommendation that The Council appoint an ad hoc committee to study the several plans for national health insurance and to make recommendations for MSMS policy.

COUNTY SOCIETIES — The Council agreed to recommend to component county societies that

(Continued on Page 412)

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they arrange for meetings at which the socio-economic-political point of view of rehabilitation care and programs can be discussed.

REHABILITATION EXHIBIT — The Council agreed that space be allocated at the next Annual Session to the Rehabilitation Committee to work with the Michigan Department of Public Health to present an exhibit on facilities available concerning programs that can be used in furthering extended care and rehabilitation for patients.

MINICONFERENCES — The Council heard a progress report on several conferences authorized by the County Societies Committee Jan. 28. Tentative arrangements have been made for a joint meeting of the socio-economics and governmental medical care programs committees on May 13 to discuss trends in medical care; for a drug abuse conference, and for a proposed meeting with executive secretaries and/or secretaries of component medical societies of MSMS.

APPOINTMENTS — The Council appointed D. R. McCorvie, M.D., Williamston, and R. E. Rice, M.D., Greenville, as delegate and alternate delegate to the Michigan Health Council. The Council reappointed Herbert A. Raskin, M.D., Detroit, to the State Comprehensive Health Planning Advisory Council, and Benjamin Jeffries, M.D., Harper Woods, to the Advisory Council to the Michigan Department of Mental Health.

HOUSE FOLLOW-THROUGH — The Council authorized sending a letter to each of the state's three medical school deans encouraging them to include materials about the organization of medicine as requested in 1969 House of Delegates Resolution 27, and another letter encouraging each school to adequately emphasize and instruct their students in general practice.

ASSISTANT PHYSICIANS — The Council voted to support the current efforts of Western Michigan University to develop a degree program to train assistant physicians and requested that the Education Liaison Committee offer its guidance and assistance to WMU in the university's early planning.

NEEDY PHYSICIANS — The Council approved appointing an ad hoc committee to study the possibility and best methods of establishing a fund to aid needy physicians and their families. The Council authorized a contribution of $200 per month for the next five months to the family of a needy Wayne County physician, with the funds being taken from the budget's contingency fund.

HEALTH SCREENING PROGRAM — The Council directed the MSMS staff to investigate a recently conducted screening program for state civil service employees and report to the County Societies Committee.

NEWSPAPER COMMENDATION — The Council instructed the president to write a letter of commendation and appreciation from MSMS to the *Detroit News* for the $3,000 reward in the *Detroit News* Secret Witness program to help solve the recent murder of Arthur D. Harris, M.D., prominent black Detroit physician.

JOURNAL REPRINTS — The Council authorized the business office to add 25 per cent to the printing costs for *Michigan Medicine* reprints to cover postage and handling charges.

HOSPITAL-DOCTOR EFFICIENCY — The Council approved an MSMS Hospital Relations Committee recommendation to request each Michigan hospital to form a coordinating advisory committee to help achieve increased effectiveness, efficiency, economy and delivery of quality medical care in hospitals.

NURSING HOMES — The Council acted to inform the Michigan Department of Public Health that MSMS objects to rules 52, 53 and 57 of the MDPH administrative rules for certifying and licensing nursing homes for participation in various government-sponsored health care programs; and that MSMS objects to the wording of rule 54 regarding countersigning of telephone or other verbal orders by the physician "within 72 hours" and requests that it be amended to read "on his next visit."

TB TESTING — The Council approved that the "Suggested Minimum Schedule for the Active Immunization of Infants and Children and Tuberculin Testing" be accepted by MSMS with the deletion of the word "Minimum" and that it be printed in *Michigan Medicine*.

ENVIRONMENTAL POLLUTION — The Council adopted a statement prepared by the Committee on Public Health as its official "Policy Statement on Environmental Pollution"; approved the Committee on Public Health's working with the Ontario Medical Association in attempts to get some kind of an international united effort to control pollution in the Great Lakes area; authorized the Publication Committee to consider allocation of space in *Michigan Medicine* for an "Environmental Health Corner" to be prepared by one of the scientific editors; and approved the appointment of Richard A. Rasmussen, M.D., Grand Rapids, as the committee's representative to the Michigan Council on Smoking and Health.

RUBELLA — The council endorsed the reporting of any cases of congenital rubella syndrome beginning Jan. 1, 1970.

PHYSICAL EXAMINATIONS — The Council authorized the Committee on Medical Aspects of Organized Athletics to assist the Michigan High School Athletic Association in the development of a new physical examination form for athletes.

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editorial viewpoints

Better Health Care For Athletes — Right and Responsibility

BY D. L. HINERMAN, M.D.
MEMBER, MSMS COMMITTEE
MEDICAL ASPECTS
OF ORGANIZED ATHLETICS

Good health care is prominent on the list of "Bill of Rights" of the athlete. With ever-increasing frequency our courts of law are finding that schools are responsible for the provision of means for such care.

It is simply inconceivable that athletic contests are sponsored in which our most physically talented young people might suffer from lack of good medical care. Yet, many athletic events and most contact practice sessions are unattended by anyone trained to recognize injury and it is an accepted fact that three out of four football players receive significant injuries during each season.

I initiated the resolution which was adopted by the House of Delegates of both the American Medical Association and the Michigan State Medical Society. This resolution urges the development of adequate athletic medical units in all schools having a sports program. Such a unit should be the necessary component of a "health team" consisting of a physician, an athletic health coordinator (trainer) who might also double as a health educator, the coaches and the parents.

IDEALLY, EVERY ATHLETIC TEAM should have a designated team physician who has had some experience in sports medicine or athletics. He should be sufficiently interested in athletics to discover the many special health problems of the athletes, and of the health coordinator (trainer) and coaches as they relate to the athlete. The physician should have intimate knowledge of the health "inventory" of each athlete. He should be immediately available during periods of contact drills as well as during regulation games.

Ideally, the athletic health coordinator (trainer) should be a physical therapist with additional training in an athletic health unit. He should be aware of the physical and mental attributes of each althlete and have rapport with the physician, players and coaches. He should be the confidant of athletes and serve as an intermediary between players, physician and coaches. He could detect and manage early phases of injury and serve effectively in the rehabilitation of the injured athlete. Many times the physician must depend upon the health cordinator to relate the events of an injury since the cordinator must be present at all times during practices when it would be unwise to tie up the physician's time.

A FUNCTIONING HEALTH TEAM composed of physician, health coordinator and coach can effectively accomplish the following things: (1) improvement of screening techniques for detecting of abnormalities before the athlete is exposed to injury; (2) provision of training programs to achieve maximum conditioning to prevent injury; (3) development of better equipment and better rules for playing the game; (4) provision of earlier and better treatment of injuries; (5) provision of effective rehabilitation of the injured athlete and (6) reduction in incidence of prolonged or permanent disability or even death from athletic injuries.

In my opinion it is only by such a health team that the athlete can have this portion of his "Bill of Rights" and the only way that schools can discharge their responsibility.

ABC

BY JOHN W. MOSES, M.D.
MSMS SCIENTIFIC EDITOR

The English language is spoken by about 500,000,000 people. Chinese is the only language used by more people.

No exact date has been established for the beginning of Old English. The first written records date from about 690 A.D. but people spoke the language before then. The Old English period lasted until about 1100, the Middle English period lasted from 1100 to about 1450, and Modern English has persisted from 1450 to the present. The English spoken in these periods differed in inflections, vocabulary and pronunciation.

Until about 450 A.D., English was called Britian and the people were known as Britons. Most of these people spoke Celtic dialects. The English language took few words from the Celtic except for names of places such as London. The Romans conquered Britain in 43 A.D. and remained in Britain until the 400's. During the next hundred years Germanic tribes (Angles, Saxons, Jutes and Frisians) conquered Britain and settled there. The language of these tribes was almost identical and formed the basis of the English language. The Romans left their mark on terms used for military and commercial items. During the 500's Latin-

(Continued on Page 419)

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Actions—Ovulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain and the United States have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives.

The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

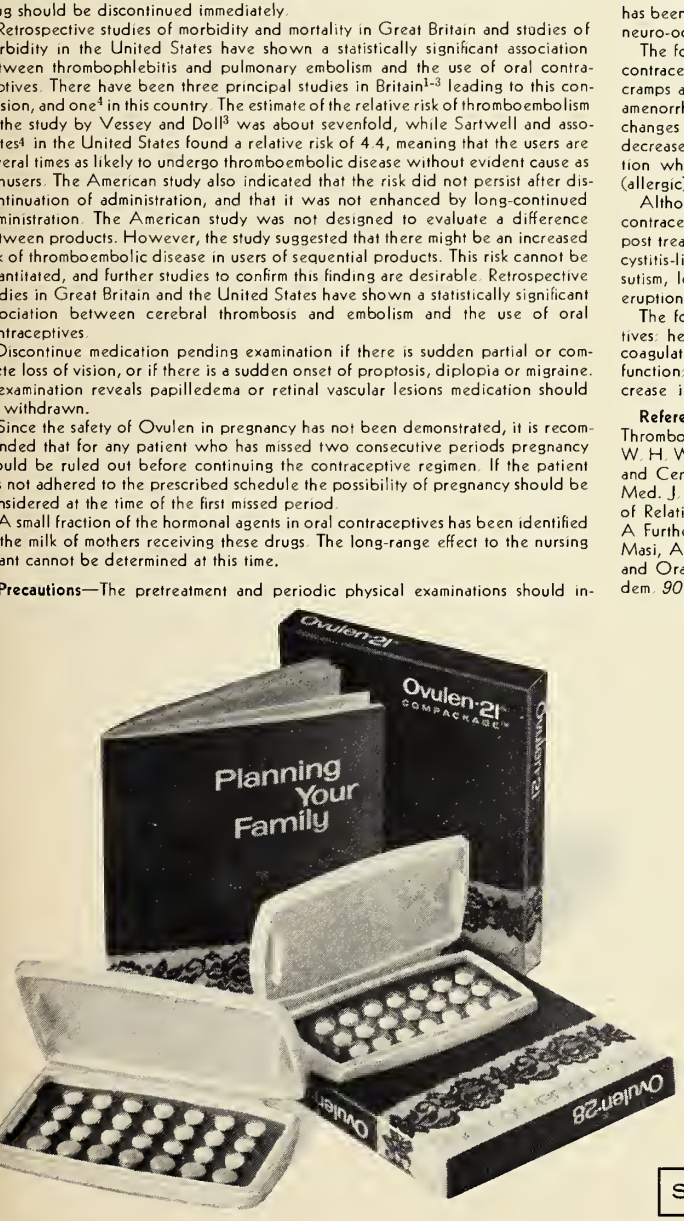
Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651:657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.



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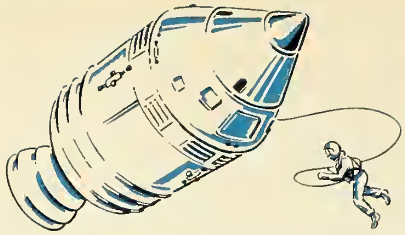

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Dosage:

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2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

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speaking Celt and Roman missionaries spread Christianity through the land leaving more Latin terms especially in the religious terminology.

DURING THE 800's Scandinavians invaded England and contributed many words to the language especially words that begin with sk-. Even more important some Scandinavian pronouns replaced English pronouns (they, them, theirs, his, him, her).

The Normans conquered England in 1066 and they replaced Englishmen as the chief landholders and officials. The Norman dialect of French became the language of the ruling class and the chief literary language and English continued as the language of the common people.

In the mid-1300's English again became the language of the ruling class; however, hundreds of French words have been assimilated into the language.

Because of the background of the language English has a larger and more varied vocabulary than any other language. There are about 600,000 English words. Many of these are technical terms used by physicians and others. Few people understand even half of the nontechnical words and we use less than a fourth of these words in everyday speech.

IN RECENT YEARS a new phenomenon has invaded the English language. Many aspects of today's changes in America are blamed on the late Franklin Delano Roosevelt (F.D.R.).

During the depression we had shortages of all kinds and this began to be noted in the language WPA, NRA, etc. Today our language is replete with abbreviations. In my teaching with students and house staff my biggest problem is not with syndromes, symptoms, disease processes, investigative data, therapeusis, etc., but rather trying to keep up with the abbreviations. At conferences and teaching rounds abbreviations are thrown around as though all were expected to know the latest time and word savers. Governmental agencies use abbreviations to drown us before we understand we are floundering.

PKU, VDRL, AHOC, SMA 12-60, SEMCOG, AHME, SCPE, MAGPGME, PL, SR, HMD, UIA, DLE, MEA, *ad infinitum* are acceptable medical and governmental abbreviations. (How many do you know?)

Archeologists have been fortunate in their excavations of ancient civilizations. They have only had to figure out hieroglyphics or ancient language. Future archeologists excavating our ruins will feel we were inarticulate or (not unlettered) but unable to put letters together to form words.

God Bless the English — let's use it.

DISSENT ......

Let Med Students Have Free Choice

(Editor's Note: The following article is reprinted with the permission of THE DETROIT NEWS, where it appeared March 1, 1970. The headline and sketch about the author are also reprinted with no changes.)

By Merle Oliver

IT IS AXIOMATIC among physicians that, no matter how enlightened and well educated the population of a community may be, 20 percent will choose other than doctors of medicine for their health care.

The explanation seems to be that every human being has an element of nonconformity in his makeup. One may be a conservative in politics, economics and social affairs and still be way out of line regarding health care. He spleens against the power and prestige of the American Medical Association. The AMA's history of reluctance to accept new ideas distresses him, even though he himself resists innovations.

Some leftwingers have a similar attitude, resenting what they regard as the holier-than-thou posture and self assurance of M.D.'s.

Then, too, there are tramp patients who move from practitioner to practitioner, seeking new opportunities to discuss their symptoms.

For these and perhaps other reasons, a fifth of the ill refuse to go to medical doctors.

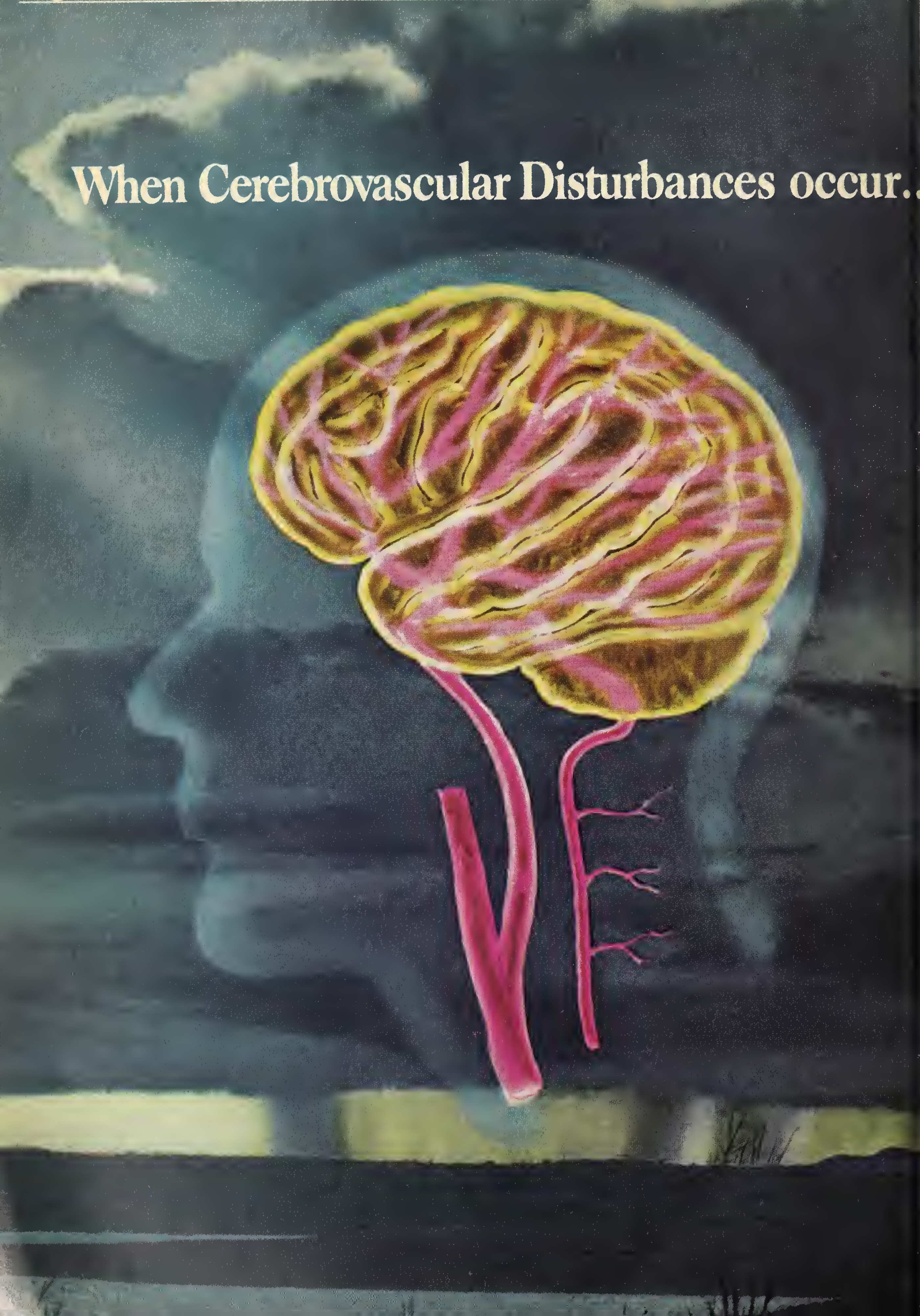
This is the best justification for having a separate osteopathic profession. The people feel that they have a choice without recourse to faith healers, electrical gadget manipulators, magnetic belt purveyors, bloodless surgeons, or other unproved sorts of practitioners.

Osteopathy was born in 1874 as a cult, based on the theory of Dr. Andrew T. Still that disease is due chiefly to mechanical derangement of the skeleton and consequent interference with the functioning of nerves and blood vessels. It has progressed to a point where osteopathic practice is nearly identical with medical practice. This re-

(Continued on Page 422)

Mead Johnson—pharmaceuticals created for your specialized clinical needs

When Cerebrovascular Disturbances occur..



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ough not all clinicians agree on the value of vasodilators in vascular disease,[1] several investigators[2-5] have reported favorably on the effects of
suprine on cerebral blood flow. Effects have been demonstrated both by objective measurement[2,5] and observation of clinical improvement.[2-4]

cations: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease),
aud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic).
position: VASODĪLAN tablets, isoxsuprine hydrochloride 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications**
Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial
ding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10
or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not
mmended. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Fazekas,
; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: Angiology *15*:No. 2 (Feb.) 1964. (2) Horton,
., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192
e) 1960. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology
2-87 (Feb.) 1964. © 1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 75970

Mead Johnson
LABORATORIES

markable advance was made under the leadership of osteopathic organizations and without scientific research. The main efforts of the leadership have been directed toward gaining legal recognition and practice rights identical with those of medical doctors in the 50 states.

Research reports of medical doctors were studied diligently and the advances were incorporated into osteopathic practice until, in effect, it became medical practice in all but name. There are some osteopaths who still feel, however, that they are "sort of specialists."

A few years ago a committee of the AMA inspected the several colleges of osteopathy in the United States (there was none in Michigan) and reported that their courses of study were essentially the same as those given in medical colleges. One small difference was that osteopathic colleges offered a course or two in manipulation. This was done to placate their old grads, the report said, and was important to their existence because these private institutions are not wealthy and they depend on contributions from their alumni.

Largely on the basis of this report, the medical and osteopathic professions of California amalgamated. Osteopaths were granted M.D. degrees, which were accepted willingly by 90 percent of California's 2,700 D.O. physicians. There was a popular referendum, and osteopathy was voted out of California except that D.O.'s already practicing there who chose to remain outside the medical profession could continue as they were. Relatively few made this choice against change, most of them older men.

The osteopathic college in Los Angeles was chartered as a medical school.

With the loss of California, Michigan became the leading state in number of practicing osteopaths. The national hierarchy of the American Osteopathic Association, anxious to hold this state in its empire, pushed plans for an osteopathic college here.

At the same time, the AOA frankly maintained an espionage system to detect early signs that D.O.'s in other states would seek to follow the example of California. The AOA is not as great in membership as the AMA but it has better means for disciplining revolt leaders.

THE AOA HAS DEMONSTRATED considerable political power, too, notably in the Michigan Legislature.

The act ordering the establishment of a college of osteopathy in Michigan is utter nonsense as regards health care and use of public funds. This is especially so with the recently established medical college at Michigan State University still awaiting full development. Modern osteopathic colleges attempt to offer the same training as medical colleges. However, D.O. clinical teaching is under a great handicap, and facilities for training in specialties are meager.

Will the two health care colleges at MSU share their poverty?

Since the osteopathic college at MSU seems to have a future of sorts, I make a suggestion, as follows:

Let all seniors in the proposed college make their own decisions on graduation day, or perhaps at the beginning of their last year. Let them have free choice between the degrees Doctor of Osteopathy and Doctor of Medicine.

How can the AOA object to that?

Merle Oliver knows whereof he dissents. Although he retired as THE NEWS' medical writer in 1965, he has kept up a lively interest, writing for a number of national medical magazines. He currently is on his fourth round-the-world trip, looking into medical practices everywhere from socialized England to Timbuktu.

MAILBAG

Michigan Medicine invites letters of 300 words or less for publication. Communications should be addressed to the Publication Committee, Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823. Unsigned letters will not be considered; but signed letters will be printed anonymously if the author so requests.

MARMP DIRECTOR THANKS MSMS

To the Editor:

I would express the formal thanks of this Association to the Michigan State Medical Society for their kindness in allowing the Annual Report of this Corporation to be printed as an insert in "Michigan Medicine."

We appreciate the suggestion that this might be done, and the cooperation in making it a reality, thus allowing the doctors of Michigan and others who read "Michigan Medicine" to have the opportunity to become acquainted with this Corporation and its stewardship.

Many, many thanks.

Albert E. Heustis, M.D., M.P.H.
Director, MARMP

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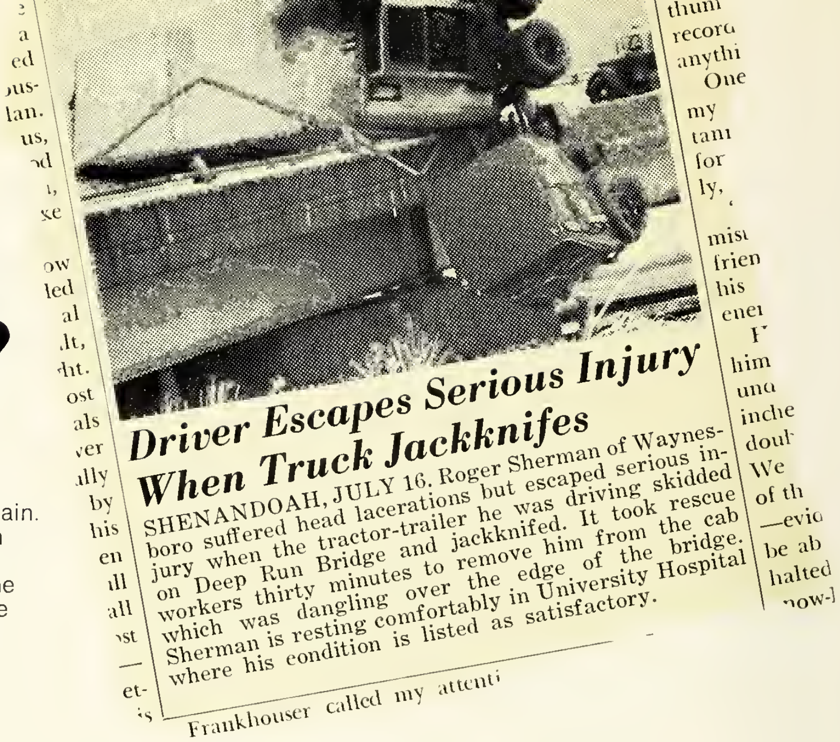

Driver Escapes Serious Injury When Truck Jackknifes

SHENANDOAH, JULY 16. Roger Sherman of Waynesboro suffered head lacerations but escaped serious injury when the tractor-trailer he was driving skidded on Deep Run Bridge and jackknifed. It took rescue workers thirty minutes to remove him from the cab which was dangling over the edge of the bridge. Sherman is resting comfortably in University Hospital where his condition is listed as satisfactory.

Frankhouser called my attenti

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg. Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg. Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. Contraindications: Hypersensitivity to any of the components. Precautions: As with all phenacetin-containing products excessive or prolonged use should be avoided. Side effects: Side effects are uncommon, although nausea, constipation and drowsiness may occur. Dosage: Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

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medical care programs

Federal Directive Issued Re Medicaid

BY HERBERT MEHLER
STAFF ASSISTANT
MSMS COMMITTEE ON
GOVERNMENTAL-MEDICAL PROGRAMS

CHP RECOMMENDATIONS STILL BEING STUDIED

The recommendations of the comprehensive Health Planning Task Force on Health care costs and Organization of Services to the Advisory Council were being studied and were not yet formal when listed in the March, 1970 issue of *Michigan Medicine*. Forthcoming issues will carry the Advisory Council's actions as the recommendations become formal.

MEDICAID

The Social and Rehabilitation Service of HEW recently issued Program Regulation 40-15 to State Administrators and other interested organizations and agencies that prescribed interim policies and requirements relating to information reporting requirements under State plans for medical assistance under Title XIX (Medicaid) of the Social Security Act.

Your attention is directed to this official directive printed in its entirety as follows:

P.R. 40-15

§ 250.71 Information Reporting Requirements, Internal Revenue Code.

State plan requirements. A State plan for medical assistance under Title XIX of the Social Security Act must provide for:

(a) Identification of providers of service by social security number or by employer identification number. When the provider is in sole practice, identification shall be by social security number. When the provider is in other than sole practice, identification shall depend upon the group's billing practices; where billing is by the individual, then identification shall be by social security number; where billing is by a partnership or a corporation, then identification shall be by employer identification number.

(b) Compliance with the information reporting requirements of the Internal Revenue Code (Title 26 U.S.C. 6041). With respect to payments for services under the plan, the Internal Revenue Code requires that annual information returns be filed showing aggregate amounts paid to providers of service identified by name, address, and social security number or employer identification number.

(c) Establishing a basis for verifying with recipients whether services billed by providers were actually received. Such basis may be by random sample of patients for each provider who is paid significant amounts under the program and for groups of providers, none of whom receive a significant amount.

FROM WASHINGTON

The President recently signed the following bills:

P.L. 91-208 extends the authorization for making grants to schools of public health.

P.L. 91-209 extends the Migrant Health Act.

P.L. 91-211 Community Mental Health Centers Act.

P.L. 91-212 Medical Library Assistance Act.

(Note: Copies of these bills are available on request to MSMS)

FEE SCHEDULES PROPOSED

Undersecretary of HEW, John Veneman, proposed Wednesday that Medicare and Medicaid be amended to control hospital reimbursement and physicians' fees . . . . .

Appearing before the Senate Finance Committee, Mr. Veneman stated, regarding hospital costs, that "with rates set in advance, a provider of medical care would be challenged to stay within the limits of the known reimbursement to be received and the provider would share in the savings that come from economies that are achieved through effective management." He said that target rates might be established for hospitals, or there could be a preclearance of hospital budgets.

With regard to physicians' fees, Mr. Veneman stated that while the Senate Finance Committee's Staff Report suggested that physicians' reimbursements be set in accordance with Blue Shield payment schedules, he believed that this would not be effective because Blue Shield would just raise their schedule of allowances. He proposed that for 1971, physicians' fees be limited either to those fees which are presently recognized or to a new prevailing level which would be set at the 75th percentile of the 1969 average customary charges for a given service in an area. . . .

Any future fee increases should be tied to an index which would be made up of a general wage and price increase in those fields which would affect the cost to the physician. Physicians' fees would continue to rise, but only in direct proportion to the other costs of the physician. Mr. Veneman was appearing before the Senate Finance Committee to present the Administration's views during the Committee's hearings on Medicare and Medicaid.

(Source: AMA Council of Legislative Activities "Legislative Roundup")

IN MICHIGAN

Listed below are official figures from the Department of Social Services showing expenditures under Medicaid (Title XIX) from January-June, 1969.

MEDICAL ASSISTANCE

Recipients and Expenditures by Type of Case and Type of Service

January - June 1969[1]

Classification	Recipients[2]	Expenditures	Average per recipient
Type of Case:			
Age 65 and over	70,160	44,159,183	629.41
Blind	1,620	584,766	360.97
Disabled	32,860	21,093,501	641.92
Families with children	168,800	23,099,431	136.84
Other children under age 21	14,580	3,291,369	225.75
Type of Service:			
Inpatient hospital care	47,260	29,785,077	630.24
Outpatient hospital care	73,220	1,797,435	24.55
Nursing home care	29,020	42,252,524	1,455.98
Physicians services	220,400	10,849,521	49.23
Other practitioners	3,300	171,747	52.04
Home health services	1,300	116,324	89.48
Laboratory and radiology	71,180	1,580,877	22.21
Prescribed drugs	170,180	5,460,719	32.09
Prosthesis	500	3,991	7.98
Ambulance	6,500	196,835	30.28
Other	440	13,200	30.00
Total	288,020	$92,228,250	$ 320.21

1. Data are based on 5 percent sample.
2. The sum of recipients by type of service add to more than the total because more than one type of service was provided to many recipients.

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

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- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

MSMS Council Supports WSU Efforts To Develop Assistant Physician Program

BY HERBERT A. AUER
STAFF ASSISTANT
MSMS EDUCATION LIAISON COMMITTEE

Upon the recommendation of the MSMS Education Liaison Committee, The MSMS Council has voted to support the current efforts of Western Michigan University to develop a degree program to train assistant physicians. The Kalamazoo Academy of Medicine and the Kalamazoo hospitals also have offered their assistance and guidance.

The MSMS House of Delegates and MSMS Council on several occasions in the past several years have encouraged the development of assistant physicians or physician assistants in Michigan. The proposal was first introduced into the MSMS House in 1965 by William G. Birch, M.D., Kalamazoo, who serves now as chairman of the subcommittee on the assistant physician.

Recently, the MSMS Education Liaison Committee held a conference for T. F. Zimmerman, Ph.D., director of the movement for the AMA, and representatives of the medical schools and WMU, the State Department of Education, the State Board of Registration in Medicine, the Michigan Comprehensive State Health Planning Office, the Michigan Health Council, and several other interested agencies and associations.

MSMS Councilor John R. Pedden, M.D., chairman of the Education Liaison Committee, reports there was "enthusiastic support" and a pledge by the medical leaders to advise and assist Western.

THE AMA EXPECTS SOON to announce the results of current study to establish perhaps three new levels of physician-support-personnel.

There are about 20 programs now in operation across the nation by colleges and hospitals to train physician support personnel. The Department of Health, Education and Welfare, which is making some federal grants to encourage such experimental programs, reports another 60 are being planned now.

The AMA reports that the Michigan State Medical Society is the only state association of physicians which has endorsed the idea and is actively working to help colleges get courses started.

The approach to the "physician assistant" idea has the support of the American Medical Association. "The AMA staff specialists in medical education are now (1) determining what functional tasks such new supporting personnel could perform, and (2) developing standards for education towards the establishment of new accrediting procedures," Doctor Pedden reported.

"Supporters in the MSMS of the physician assistant idea contend," Doctor Pedden said, "that such a new person would free the doctor from the more routine tasks and thus give him more time to care for more patients and to concentrate on those patients requiring his specialized skills."

Medical society officials have placed the doctor shortage in Michigan today at 2,000 physicians and estimate that Michigan will need 5,000 more physicians in 1975 than it now has.

Michigan Authors

C. Howard Ross, M.D., Ann Arbor, "Education and the Geriatric Purse," page 24, *Journal of the American Geriatrics Society,* January, 1970.

Charles M. Wylie, M.D., Dr. P.H., "The Definition and Measurement of Health and Disease," page 100, *Public Health Reports,* February, 1970.

J. Martin Miller, M.D., Detroit, comments in "Forum" on the relationship and therapeutic implications of non-toxic nodular goiter to thyroid cancer, pages 212-213, *Modern Medicine,* February, 1970.

Bruce Proctor, M.D., Royal Oak, "Surgical Anatomy of the Posterior Tympanum," page 1026, *Annals of Otology, Rhinology and Laryngology,* October, 1969.

Alexander H. Hirschfeld, M.D., Detroit, "Medicine in the Inner City," page 57, *Delaware Medical Journal*, March, 1970.

STUDY OF THE LEGISLATURE was conducted by M. A. Riley, MSMS legislative counsel, as members of the Woman's Auxiliary to MSMS gathered for the early sessions of their third annual Legislative Day recently. Their headquarters for lessons in the workings of the legislature and a luncheon with their legislators were at the Capitol Park Motor Hotel, Lansing. Later they toured the Capitol itself and sat in on a legislative session.

WIVES OF PHYSICIANS from around Michigan entertained their home town legislators at luncheon during the recent legislative day, which provided a chance for women and legislators to become better acquainted. From left at a typical table were Sen. Oscar Bouwsma, Mrs. Donald Hack, Rep. Barney Hasper, Mrs. Richard Torrey, Mrs. Frank Garber, Jr., and Rep. Edgar Geerling, all of Muskegon.

MSMS Womans Auxiliary Stages Legislative Day

AN INFORMAL CHAT with Michigan legislator James D. Gray of Warren is enjoyed at the recent annual MSMS Woman's Auxiliary Legislative Day by from left, Mrs. Edward F. Maxim, Saint Clair Shores, auxiliary president; Mrs. Philip Lange, Lansing, auxiliary legislative chairman and Mrs. James Stanton of Mt. Clemens.

Doctor, after all we've been through together...

- abscess
- acne
- amebiasis
- anthrax
- bacillary dysentery
- bartonellosis
- bronchitis
- bronchopulmonary infection
- brucellosis
- chancroid
- diphtheria
- endocarditis
- genitourinary infections
- gonorrhea
- granuloma inguinale
- listeriosis
- lymphogranuloma
- mixed bacterial infection
- osteomyelitis
- otitis
- pertussis
- pharyngitis
- pneumonia
- psittacosis
- pyelonephritis
- Rocky Mountain spotted fever
- scarlet fever
- septicemias
- sinusitis
- soft tissue infection
- tonsillitis
- tularemia
- typhus fever
- urethritis

...don't you think it's time we were on a first-name basis?

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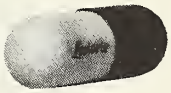

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Contraindications: Hypersensitivity to tetracycline.
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Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

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1970 Conference On Maternal Health Largest Ever

Registration
AND INFORMATION
MICHIGAN
CONFERENCE ON
MATERNAL AND
PERINATAL HEALTH

LARGEST CROWD EVER overflowed the ballroom of the Pick-Durant Hotel in Flint recently for the ninth annual Michigan Conference on Maternal and Perinatal Health. Total registration was 525. Among the crowd were Flint physicians Thomas B. Flores, M.D., left, and George Tumaneng, M.D.

MICHIGAN PARTICIPANTS were registered by MSMS staff members Miss Helen Schulte, left, and Mrs. Jean Hirschy. The physicians are Roman R. Knoblich, M.D., Flint, and George E. LaCroix, M.D., Detroit, right.

WELCOMING TORONTO SPEAKER Paul R. Swyer, M.B., M.R.C.P., center, were Ralph S. Steffe, M.D., Flint, left, president-elect of the Michigan Society of Obstetricians and Gynecologists, and John P. Harm, M.D., Detroit, assistant professor of pediatrics, Wayne State University School of Medicine, moderator of a panel on the second-days' program. The MSOG for the first time co-sponsored the conference with MSMS and the Clara Elizabeth Fund of Flint.

FIRST-DAY PARTICIPANTS, from left, Burris Duncan, M.D., director of community pediatrics University of Colorado School of Medicine, Denver; Ann M. Smith, R.N., M.S., pediatric nurse practitioner, University of Colorado Medical Center, Denver, and Carmela Cavero, C.N.M., M.S., assistant professor of nurse-midwifery, College of Health-Related Professions, Downstate Medical Center, Brooklyn, N.Y., gather at an exhibit in the Flint hotel.

KEYNOTE SPEAKER Harry Prystowsky, M.D., right, professor and chairman, Department of Obstetrics and Gynecology, University of Florida College of Medicine, was introduced following the banquet by Darrell E. Statzer, M.D., Detroit, member of the MSMS Committee on Maternal and Perinatal Health, and chairman of the 1970 Maternal Health Conference. Doctor Prystowsky's topic was "The University Role in the Delivery of Health Care."

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- Blue Shield now with Michigan Variable Fee coverage, MVF, has many new and expanded benefits including unlimited days of in-hospital medical care plus coverage of surgical care.
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When statistics say that one in every three families will need hospital or doctor care during the coming year, you can't afford to take chances with your health. Don't gamble. You can get the most Blue Cross and Blue Shield coverage at the lowest cost through your group.

The enrollment period for members of the Michigan State Medical Society will be May 10 to June 1, 1970. Your coverage will be effective August 1, 1970.

Be prepared for the future . . . join now!

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The treatment of

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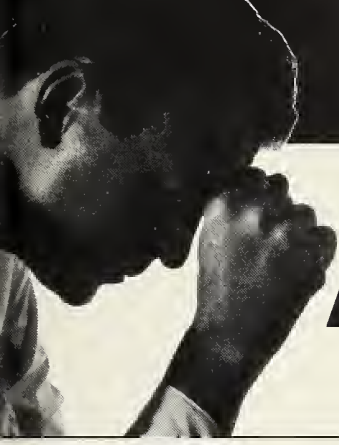
in the American male is complex.
The concept of chemotherapy plus the
physician's psychological support is confirmed
as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence
with Methyltestosterone Thyroid
(100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the
American Fertility Society



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Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Ketosteroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Contraindications — Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
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Pyridoxine HCL ....5 mg.
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PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

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county societies

Berrien Physicians Learn Of Radio-Isotope Scanning

Radio-Isotope Scanning Procedures was the topic of speaker Gene E. Maddock, M.D., Benton Harbor-St. Joseph area radiologist, at a recent meeting of the Berrien County Medical Society. Radioisotope scanning is soon to be made available as a diagnostic tool in Berrien County.

Huron County Members Hear State Legislator

Senator Alvin DeGrow addressed the wives and members of the Huron County Medical Society on March 24 in Bad Axe.

The program was arranged by Secretary Robert A. Willits, MD, and President Kenneth S. Kube, MD, both of whom praised Senator DeGrow for his strong support of the Michigan State Medical Society's position on the 1969 legislation pertaining to an osteopathic college.

Doctor Kube read a letter from the Michigan State Medical Society Legislative Counsel, Mike Riley, pointing out the great additional help Senator DeGrow had lent in the case of several other important health bills.

MSMS was represented by Associate Director Warren Tryloff who spoke briefly on the current trends in professional liability insurance.

Ingham Physicians Honor Fair Winners

The Ingham County Medical Society made available $50 savings bonds to the two top winners of the junior science division of the 23rd Annual Central Michigan Youth Talent Exhibit and Science Fair held early in April at the Civic Center, Lansing. There were more than 150 exhibits in the Science Division of the fair.

Kalamazoo Lawyers, Doctors Hold Joint Meeting

The recent joint meeting of the Kalamazoo Academy of Medicine and the Kalamazoo County Bar Association featured a discussion on the “Hazards of Professional Incorporation" by Attorney Joseph D. Hartwig of Benton Harbor, former chairman of the Valuation Procedures Committee, Taxation Section, American Bar Association, and former chairman of the Taxation Section of the Michigan Bar Association. The joint meeting was renewed by the county's doctors and lawyers after a lapse since 1964.

Kent, Marquette Counties Hold Medicine-Religion Meetings

The Kent County Medical Society and the Marquette-Alger County Medical Society Committees on Medicine and Religion held recent joint meetings between physicians and their clergymen. The Kent County's M and R day featured a workshop in drugs and drug problems, highlighted by the appearance of the AMA's new traveling drug exhibit. The Rev. Paul McCleave, Chicago, head of the AMA's Department of Medicine and Religion, spoke at the M and R day in Marquette. His topic was "Dialogue in Modern Medicine."

Lenawee Physicians Host Local Med Students

Members of the Lenawee County Medical Society were hosts to eight of the county's 11 medical students at a dinner meeting when the students were home during a recent vacation. A program on allergenic diseases was presented by a Toledo specialist. Plans are to expand the meeting in the future to include an afternoon tour of medical facilities, hospitals and offices in the county. The students represented all three of Michigan's medical schools, as well as Northwestern University and Chicago Osteopathic School. Arrangements were made by Donato Sarapo, M.D.

Doctor Breneman Addresses Macomb Society

James C. Breneman, M.D., Galesburg, was guest speaker at a recent meeting of the Macomb County Medical Society. He discussed "Thromboembolic Disease." Doctor Breneman is affiliated with Borgess Hospital, Kalamazoo.

Northern Michigan Society To Admit Osteopaths

Members of the Northern Michigan Medical Society voted at their March meeting to extend eligibility for membership to osteopathic physicians. Peter J. Connaughton, M.D., president of the NMMS, said the society would like to encourage participation by the osteopathic physicians in programs, committees and activities sponsored by the society.

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A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): 1/2 tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

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rheumatoid spondylitis, and osteoarthritis of the hip

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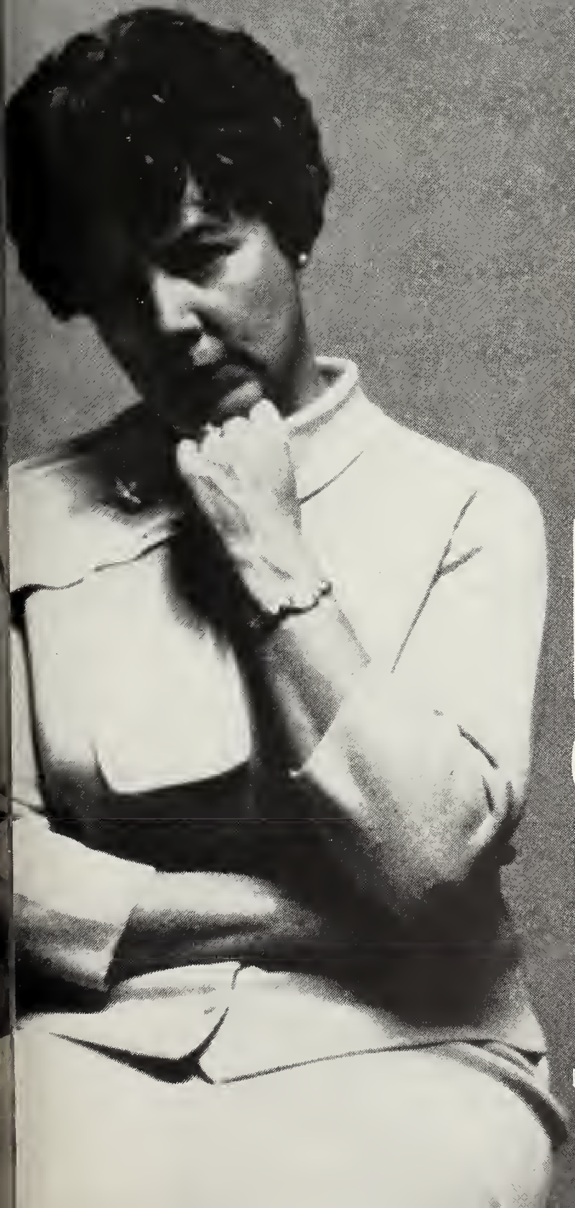

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General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Indications: Symptomatic relief of adult rheumatoid and degenerative joint disease unresponsive to adequate trial of salicylates and other measures of established value, such as appropriate rest. Has been found effective in active stages of: 1) moderate to severe rheumatoid arthritis including acute flares of chronic disease, 2) moderate to severe rheumatoid (ankylosing) spondylitis, and 3) moderate to severe degenerative joint disease of the hip (osteoarthritis of the hip). Has been found effective in relieving pain and reducing fever, swelling, and tenderness in acute gouty arthritis in selected patients. May enable reduction of steroid dosage in patients receiving steroids for the more severe forms of rheumatoid arthritis; in such instances the steroid dosage should be reduced slowly and the patients followed very closely for any possible adverse effects.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

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about doctors

Doctor Schooten in Top 10 Of Detroit's Working Women

Sarah S. Schooten, M.D., Detroit, has been named one of the Top 10 Working Women of Detroit by the Greater Detroit Chamber of Commerce. She and the nine other working women were honored with a two-day series of special receptions, climaxed by an awards banquet at Cobo Hall.

Doctor Schooten, 75, is a full-time pediatrician, on the staffs of four Detroit hospitals and is attending physician for the children of St. Vincent's and Sarah Fisher homes in Detroit. She holds the William Booth Founders award from the Salvation Army and recently represented the U.S. at the Medical Woman's International Association convention in Melbourne, Australia.

DAVID G. ANDERSON, M.D., ANN ARBOR, has been elected president-elect of the Norman F. Miller Gynecologic Society of physicians trained in obstetrics and gynecology at the University of Michigan under Doctor Miller and J. Robert Willson, the current chairman of the department and president-elect of the American College of Obstetricians and Gynecologists. Other new officers, all graduates of the U-M, are Warren H. Pearse, M.D., Omaha, Neb., president; Crosby J. Eaton, M.D., Ann Arbor, secretary; David H. Middleton, M.D., Ann Arbor, treasurer; and council members James P. Youngblood, M.D., Kansas City, Mo.; Robert L. Range, M.D., Sacramento, Calif.; A. Gordon Reynolds, M.D., Redlands, Calif., and Harry C. George, M.D., East Lansing.

MARY CRETENS, M.D., GLADSTONE, director of the Delta-Menominee District Health Department, received a special certificate of achievement recently from the Michigan TB and Respiratory Disease Association for her work during the recent State-Wide Tuberculin Testing Program.

JOHN M. DORSEY, JR., M.D., BIRMINGHAM, a pediatrician, discussed drug abuse at a statewide PTA Problem Clinic at Kellogg Center, East Lansing, recently.

JOHN M. DORSEY, SR., M.D., DETROIT, was honored recently by the City of Detroit for his "faithful leadership and service" as the chairman of the Mayor's Committee for the Rehabilitation of Narcotic Addicts, since its inception in March, 1951. Doctor Dorsey, who resigned the chairman post, was presented with a framed certificate and plaque by Mayor Roman S. Gribbs, who proclaimed Dr. John M. Dorsey Day.

ALLEN J. ENELOW, M.D., EAST LANSING, and JEROME W. CONN, M.D., ANN ARBOR, took part in a recent Frontiers of Medicine 1970 program sponsored in Florida by the Lakeland, Fla., Graduate Medical Assembly. Doctor Enelow is chairman of the Department of Psychiatry at Michigan State University in East Lansing, and Doctor Conn is professor of internal medicine and director of the Department of Endocrinology and Metabolism at the U-M.

WILLIAM J. HANLEY, M.D., MUSKEGON, received a resolution of appreciation and engraved plaque recently for his services rendered as president of the new Muskegon County Medical Facility's medical advisory staff.

KARL S. KLICKA, M.D., WAYNE, was recognized in a feature in the *Wayne Dispatch,* a western Wayne County weekly. The story, entitled "PCHA Has a New Image—Doctor Karl Klicka Makes it Click," lauded the physician for administering the Peoples Community Hospital Authority since 1966 in a manner that permits the PCHA to "face the community and the world with not only a clean slate but as a pinnacle of recognition in the entire world of public health services."

CHARLES O. LONG, JR., M.D., EAST LANSING, is one of 77 radiologists awarded a Fellowship degree by the American College of Radiology for outstanding contributions to medicine. The award was presented at the ACR annual meeting in Dallas recently.

FREDERICK J. MARGOLIS, M.D., KALAMAZOO, received an honorary doctoral degree from Western Michigan University at winter commencement exercises.

FREDERICK J. MELGES, M.D., BATTLE CREEK, has received the *Battle Creek Enquirer and News's* George Award for outstanding community service. Doctor Melges has delivered nearly 10,000 babies since coming to Battle Creek in 1931, has worked four years with the Calhoun County Health Department's Family Planning Clinic, served four years with the Battle Creek City Commission, is former president of the Battle Creek Civic Center organization, is a past president of the Calhoun County Medical Society and former chief of staff of the Battle Creek Community Hospital.

(Continued on Page 442)

I love my family. I adore this house. My in-laws are great. The neighbors are wonderful

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m complex to medical and surgical disorders
cedures. Though not a hypnotic, fosters
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ndications: History of sensitivity to
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o overdose themselves. Excessive prolonged
been reported to result in dependence or
tion in susceptible persons, as alcoholics,
cts, and other severe psychoneurotics.
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dose if drowsiness, ataxia or visual
ance occurs; if persistent, patients should
rate vehicles or dangerous machinery.

ects include drowsiness, usually transient;
stent and associated with ataxia, usually
ds to dose reduction; occasionally
tant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

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I'll scream
f I don't get away!

NEW AND VETERAN
physicians on the Addison Community Hospital staff were honored at a recent open house in the Addison High School cafeteria. The activity, sponsored by the Inter-Lakes Lions Club, the Addison Kiwanis Club and the Addison Hospital Boosters, provided an opportunity for community residents to meet the doctors and their families and become better acquainted with the hospital.

JOSEPH N. SCHAEFFER, M.D., DETROIT,
director of the Detroit Rehabilitation Institute, Inc., has been named to a new 21-member Governor's Commission on Employment of the Handicapped.

JEREMIAH TURCOTTE, M.D., ANN ARBOR,
is the recipient of the 1970 Henry Russel Award from the University of Michigan. Doctor Turcotte, a pioneer in kidney transplant surgery for the past 10 years, was recognized as a young member of the U-M faculty showing scholarly achievement and promise.

C. MARK VASU, M.D., GRAND RAPIDS,
has been re-elected president of the Kent County Unit of the Michigan Heart Association. Among officers serving with him is Vernon E. Wendt, M.D., Grand Rapids, second vice president.

ARTHUR W. WEAVER, M.D., DETROIT,
has received the Director's Commendation from the Veterans Administration for his outstanding service to the public in the campaign against smoking.

ALFRED H. WHITTAKER, M.D., DETROIT,
recently received the Ohio State University Centennial Award for outstanding service to the university since graduation. He was one of 206 alumni across the country to receive the award.

HACKLEY E. WOODFORD, M.D., BENTON HARBOR,
is moving his practice to Pasadena, Calif., after 28 years as a Michigan physician. Doctor Woodford is joining the Permanente group clinic in Pasadena, which provides medical services and hospital care for patients on an annual subscription basis.

DOUGLAS C. YOUNGMAN, M.D., MARION,
was named his community's outstanding citizen at annual Chamber of Commerce ceremonies recently. Doctor and Mrs. Youngman have resided in Marion for 22 years. Doctor Youngman is a member of Marion's Industrial Development Committee and has been responsible for the building of about 20 new homes in the community. He is former chief of staff at Cadillac's Mercy Hospital and has served on the Board of Education for six years.

ER HILTON
Charter

A group of Michigan physicians providing hospital emergency room care have become the second state chapter of the American College of Emergency Physicians. Their charter was presented recently by John G. Wiegenstein, M.D., Lansing, left, chairman of the ACEP, to Daniel Landron, M.D., Jackson, state board member. Future activities of the state chapter will include joint sponsorship with the Michigan Chapter, The American College of Surgeons, of a trauma meeting June 11-12 at Gaylord and a business-scientific meeting in September in Detroit.

A new Duncan J. McColl Memorial Fund in Gynecology and Obstetrics has been established at the Wayne State University School of Medicine in memory of the late Duncan J. McColl, M.D., of Port Huron, who was WSU's oldest living alumnus when he died at the age of 99 on May 25, 1968. WHU President William R. Keast, seated left, accepted a $25,000 check establishing the fund from Sheldon G. Hayes, seated right. Looking on were Joseph S. Radom, standing left, an attorney for the foundation, and Clark M. McColl, M.D., Detroit, a member of the foundation board and son of the late Doctor McColl, who delivered more than 8,000 babies in his medical career.

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SOLVES THEM

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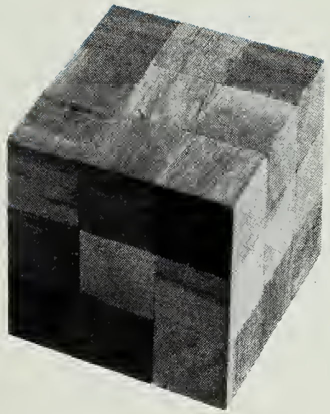

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Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
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Caution: Federal law prohibits dispensing without a prescription.

Action and Uses: Urised is effective in cystitis, pyelitis, trigonitis in pregnancy, urethritis, and other urinary tract infections where the invading organisms, such as E. coli, S. aureus and albus, are susceptible to methenamine and methylene blue in an acid medium.

URISED also is useful as a prophylactic measure prior to urinary tract instrumentation or operation. In acute fulminating infections, URISED may be used for symptomatic relief while awaiting specific laboratory diagnosis. May be combined with specific therapy where indicated.

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Adults: Two tablets, orally, four times per day, followed by liberal fluid intake.

Children: One-half the adult dose.

Acute cases: Initially two tablets every hour for three doses, followed by the recommended daily administration.

Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Side Effects: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

How Supplied: Bottles of 100, 500 and 1,000 tablets.

References: (1) Sands, R. X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M. J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest. Med. 42:30-32, 1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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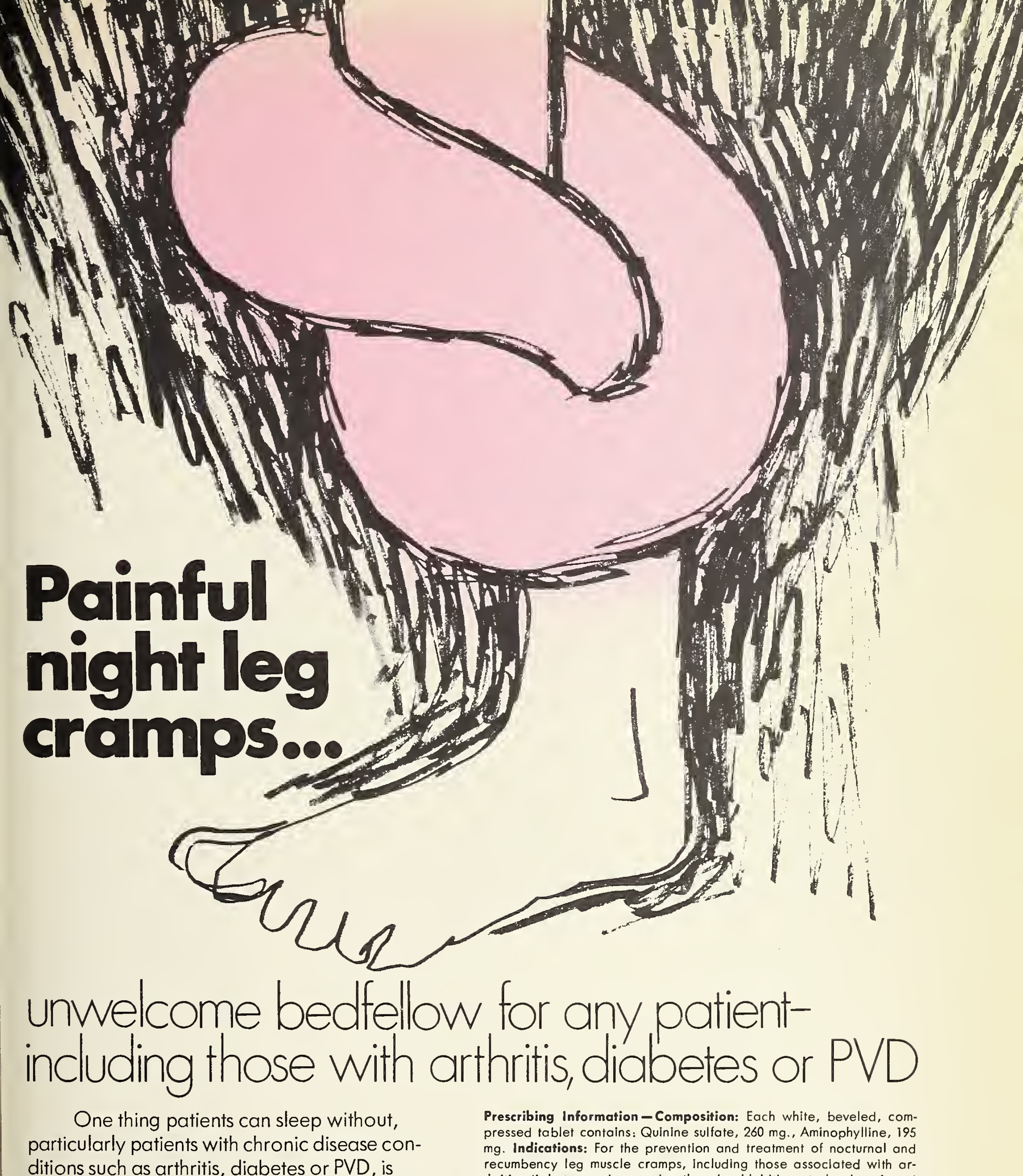

Painful night leg cramps...

unwelcome bedfellow for any patient— including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps
(quinine sulfate 260 mg., aminophylline 195 mg.)

Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.
References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrondt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. 8., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allontain 0.014 Gm.)

TRADEMARK: A V C AV-919A 7/69

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LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

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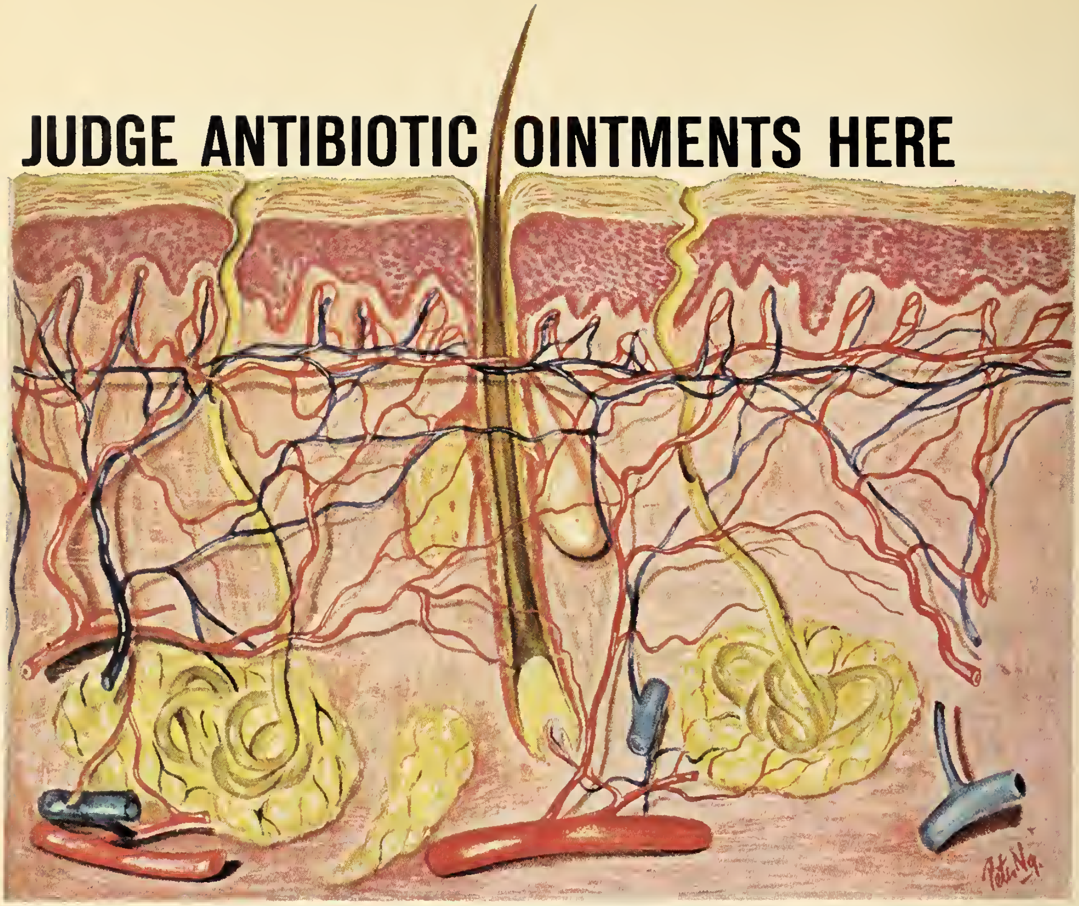

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IN EMPHYSEMA

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When ephedrine is too exciting or is contraindicated

MUDRANE GG
During pregnancy or when K.I. is contraindicated or not tolerated

MUDRANE GG-2
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MUDRANE GG ELIXIR
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CAUTION:
OVEREATING MAY BE HAZARDOUS TO YOUR HEALTH.

According to the Framingham Heart Study, the obese face:

86% greater risk of angina pectoris,
82% greater risk of diabetes,
71% greater risk of coronary heart disease.*

Obesity may also aggravate osteoarthritis, flat feet, intertriginous dermatitis, varicose veins, and ventral or diaphragmatic hernias.[1-3]

If you are considering weight reduction, consider

Preludin®

phenmetrazine hydrochloride Endurets® prolonged-action tablets

Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

Long acting

Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

Once-a-day dosage

One Endurets tablet after breakfast. It helps reduce weight and costs, conveniently.

For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., et *al.*: *Circulation* 35:734, 1967.

2. Thomas, H.E., Jr., et *al.*: *Med. Times* 95:1099, 1967.

3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.
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in memoriam

Joseph R. Barton, M.D.
Dearborn Heights

Joseph Roy Barton, M.D., medical director of the Detroit Children's Aid Society for over 30 years, died Jan. 23 at the age of 73.

Doctor Barton, a graduate of St. Louis University School of Medicine, was affiliated with Mt. Carmel Mercy Hospital in Detroit. A general practitioner, he made his home in Dearborn Heights.

Doctor Barton had been a pediatrics instructor at Wayne State University and was a member of the Detroit Pediatric Society. He was a life member of MSMS.

Ernest W. Bauer, Sr., M.D.
Berkley

Ernest W. Bauer, Sr., M.D., Berkley, suburban Detroit-area physician for nearly 50 years, died March 16 at the age of 72.

Doctor Bauer was a graduate of the University of Michigan Medical School and was former president of the Oakland County Medical Society. He served on the fund-raising committee for Woodward General Hospital, the forerunner to Beaumont Hospital, led Red Cross blood drives and was a member of the Hazel Park first charter commission.

Frank K. Beck, M.D.
Port Huron

Frank King Beck, M.D., Port Huron General Practitioner for 30 years, died March 10 at the age of 69.

Doctor Beck was a graduate of Loyola University's Stritch School of Medicine and was affiliated with Port Huron General and Mercy Hospitals in Port Huron. He was a member of the American Association of General Practitioners and had practiced in Coleman, Mich., before moving his practice to Port Huron in 1940.

Isadore I. Bittker, M.D.
Detroit

Isadore Irving Bittker, M.D., Detroit-area general practitioner over 50 years, died March 16, at the age of 76.

Doctor Bittker was a member of the consultation staff of Evangelical Deaconess Hospital in Detroit and served as a diagnostician for the Detroit Department of Health from 1917 to 1942. He was a member of the Wayne County Medical Society for 52 years. He was a graduate of the Detroit College of Medical Surgery.

Lewis E. Dunn, M.D.
Lathrup Village

Lewis Edgar Dunn, M.D., Berkley physician for 20 years, died March 18 at the age of 57.

Doctor Dunn was a graduate of Wayne State University School of Medicine and was affiliated with St. Joseph Mercy Hospital in Pontiac. A general practitioner, he made his home in Lathrup Village.

Nicola Gigante, M.D.
Detroit

Nicola Gigante, M.D., a Detroit internist for 43 years, died March 31 at the age of 74.

Doctor Gigante was a graduate of the University of Rome medical school and was appointed to the staff of Harper Hospital in 1927, where he continued until his death. He was the founder and president of the American Medical Relief Committee of Michigan and served for six years on the State Tuberculosis Sanatorium Commission.

He worked for flood relief and assistance to homeless boys in Italy and founded the American Committee for Italian Migration in Detroit. In 1964 he received the Italian-American Chamber of Commerce Distinguished Citizen Award and he was decorated by the Italian Government with the Star of Solidarity.

Doctor Gigante was a member of the American College of Physicians.

John B. Hartzell, M.D.
Grosse Pointe Farms

John Berry Hartzell, M.D., Detroit surgeon, died March 22 at the age of 70.

Doctor Hartzell, a governor of the American College of Surgeons and a trustee for the Central Surgical Association and the Western Surgical Association, was well known for his 1929 experimental work in cutting the vagus nerve to reduce gastric acidity affecting the relationship of nerves to that problem.

Doctor Hartzell was a graduate of the University of Cincinnati School of Medicine and had served at the Mayo Clinic. He was a former chief of staff and former chief of surgery at Jennings Hospital, former Wayne State University assistant clinical professor at Receiving branch of Detroit General Hospital and a former adjunct staff member of Harper Hospital.

(Continued on Page 454)

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Abraham J. Hollander, M.D.
Dearborn

Abraham Julius Hollander, M.D., Detroit area internist, died Jan. 7 at the age of 70.

Doctor Hollander, who was graduated from the University of Virginia School of Medicine, was affiliated with Oakwood Hospital, Dearborn. He was past president of the Dearborn Medical Society and belonged to the American Academy of General Practice.

Donald F. LeMire, M.D.
Escanaba

Donald Francis LeMire, M.D., Escanaba general practitioner, died Feb. 27 at the age of 53.

A graduate of Loyola University School of Medicine, Doctor LeMire was affiliated with St. Francis Hospital in Escanaba. He was a past president and past secretary of the Delta-Schoolcraft County Medical Society.

Stephen Malina, M.D.
Detroit

Stephen Malina, M.D., a Detroit-area physician since 1938, died Feb. 21 at the age of 61.

Doctor Malina, a radiologist, was affiliated with St. Joseph Mercy Hospital in Detroit, and was a graduate of Ohio State University School of Medicine. He was a member of the American College of Radiology and the Detroit Roentgen Ray Society.

John P. Surbis, M.D.
North Miami, Fla.

John P. Surbis, M.D., Detroit physician for 30 years until his retirement several years ago, died March 12 at the age of 67. He was residing in North Miami, Fla.

Doctor Surbis was a graduate of Tufts Medical School and lived in Dearborn before his retirement.

Stuart Yntema, M.D.
Saginaw

Stuart Yntema, M.D., who had practiced medicine in Saginaw since 1922, died March 10 at the age of 72.

Doctor Yntema is former Saginaw City Health officer, former Saginaw school physician, former medical director and consultant at the Saginaw County Tuberculosis Hospital. He had been president of the Saginaw General Hospital staff.

From 1942-44 Doctor Yntema was chief of medical service at Fort Custer Regional Hospital and then at Percy Jones General Hospital near Battle Creek. He was a graduate of Rush Medical College of the University of Chicago.

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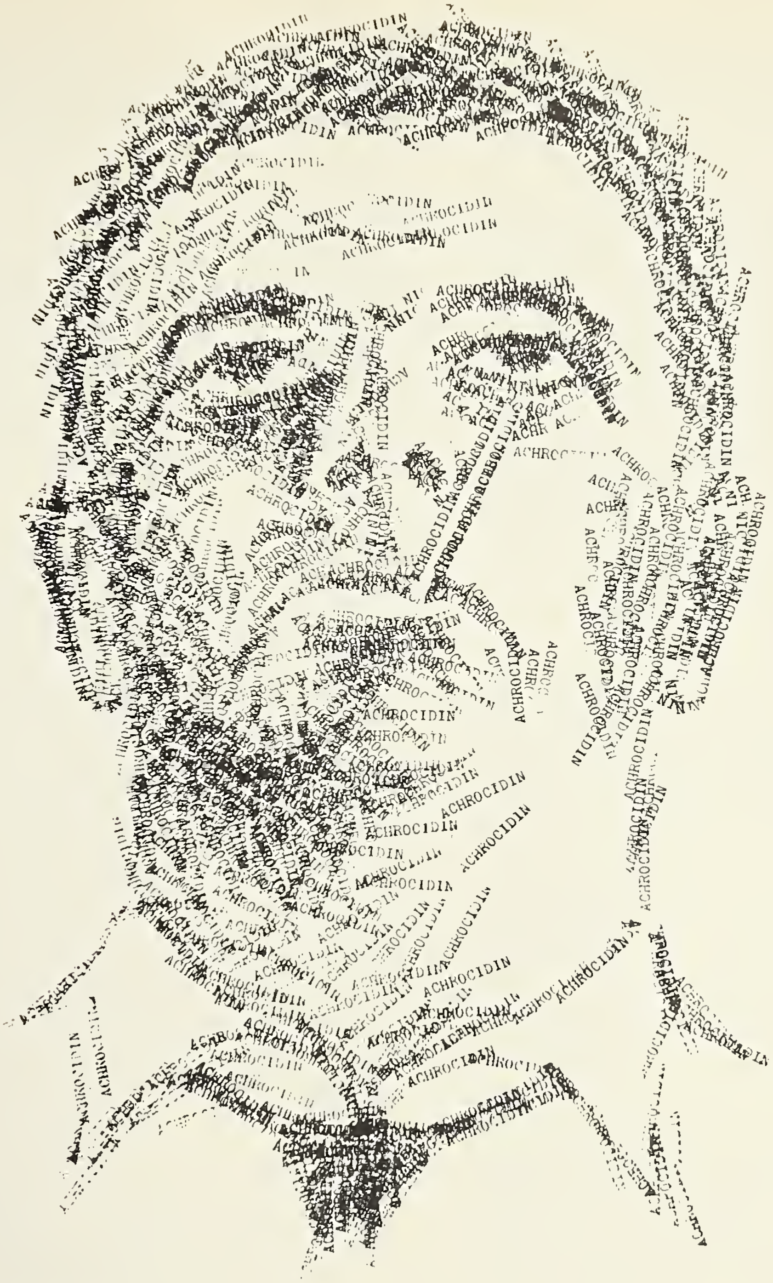

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Contraindications: Hypersensitivity to any component.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.
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ASSOCIATE NEEDED: Three man surgical and industrial group desires associate willing to assist in surgery, do office work consisting of private patients, industrial accidents and employment examinations. Ideal for qualified G.P. South central Michigan area. Reply Box #10, 120 W. Saginaw Street, East Lansing, Michigan 48823.

FOR LEASE: In new medical, dental building. Four suites available, or will combine. (Total 4200 sq. ft.) will design to your specifications. Located in the city of Grandville, Michigan. Easy access to shopping centers, expressways and housing. Lease includes paved offstreet parking, all utilities and services. Reply to Prairie Street Realty Company, 2700 28th Street, S.W., Grand Rapids, Michigan 49509 or phone (616) 538-9000.

POSITION DESIRED: General practice or locum tenens. Available July 5 through September 5, 1970. University of Michigan Medical School graduate with Michigan license. Rotating internship at Parkland Memorial Hospital, Dallas, Texas. Also interested in emergency room position. Write: Robert M. Williams, M.D., 2110 Belt Line Road 225-B, Carrollton, Texas 75006.

DOCTORS—Munising, Michigan, has a drawing area of 10,000 people with its excellent schools, best water sports, and hunting in the Great Lakes and a 35 bed modern hospital with an ICCU, physical therapy, inhalation therapy, and surgery. There is an opening for a general surgeon or general practitioner who would like to do some general practice and surgery and work with a young general practitioner. The offices are located next to the hospital. If interested, contact Neil Grossnickle, M.D., Sand Point Road, Munising, Michigan 49862.

Do you and your family like to boat, sail, swim, hunt, golf or ski? Enjoy all while practicing in a growing progressive community. Unusual opportunity for a young internist to take over an established practice due to retirement June 1st. New 90 bed hospital to be completed this summer with modern facilities and coronary care unit. Fully equipped, modern office available. Will introduce. Contact: E. B. Miller, M.D., 324 First Street, Manistee, Michigan 49660 or call (616) 723-2346.

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WANTED: Internist to join two man partnership in Michigan's upper thumb area. Excellent recreation and educational facilities are available. Write to: K. G. Herrington, M.D. or Kenneth S. Kube, M.D., 669 South Van Dyke, Bad Axe, Michigan. May call collect: (517) 269-6453.

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INTERNIST: Attractive well established practice available. Can promise excellent income from first day. Will rent or sell office building. Two blocks from 400 bed hospital. Western Michigan community of 125,000 on Lake Michigan. Hunting, fishing, and winter sports near by. Write Box #7, 120 W. Saginaw St., East Lansing, Michigan 48823.

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GENERAL PRACTITIONER desperately needed for progressive town of 5,000, just 25 min. from Grand Rapids. Mutual coverage arrangements with remaining M.D. (in practice here 8 years) ensures time off to enjoy most rewarding living, as well as working experience in this friendly town. Contact L. E. Sanford, M.D., 204 Pearl Street, Belding, Michigan. Phone: (616) 794-0801, (collect).

UROLOGIST, 35, Michigan License, finishing residency in June 1971, excellent references and experience. Seeks Association, leading to partnership or group practice. Available July 1971. Write V. S. Grewal, M.D., 17160 Whitcomb, Apt. #114, Detroit, Michigan 48235.

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Burroughs-Wellcome & Co. 448
Campbell Soup Co. 415
Classified Ads 456, 457
Conal Pharmaceuticals 443
Dow Chemical Co. 447
Geigy Pharmaceuticals 450, 451
Hoechst Pharmaceuticals 405
Hynson, Westcott and Dunning, Inc. 379
Lederle Laboratories 380, 429, 455
Lilly, Eli and Co. 384
Loma Linda Foods 407
Mead-Johnson Laboratories 420, 421
Medical Protective Co. 411
Merck, Sharp and Dohme 436, 437, 438
Mercywood Hospital 433
Michigan Medical Service 432
Michigan State Medical Society 453
National Drug Co. ....Cover II, 445, 446
Plainwell Sanitarium 426
Poythress, Wm. P. 418, 449
Professional Management 411
Robins, A. H., Company 423, 424
Roche Laboratories ....Cover IV
Searle, G. D., and Co. 416, 417
Stratton, Ben P., Ins. ....Cover III
Stuart Pharmaceuticals, Division of
  Atlas Chemical Industries, Inc. 444
Walker Corp. and Co. 434, 435
Wyeth Laboratories 440, 441

noted and quoted

BY HERB AUER, EXECUTIVE EDITOR

"There is tough work to be done," declares Jenkin Lloyd Jones, President of the National Chamber of Commerce and editor of the Tulsa *Tribune*.

He points out that: "Today, for all our wealth, we couldn't begin to afford a government big enough to deal with all the problems people are stirred up about — even if our freedom could stand such massive government interference, which it couldn't, and even if government had all the answers to begin with, which it doesn't.

"So, we're back where we were. Only voluntary action can save the day."

* * *

The Bay City *Times* in a recent editorial about hospital costs and medical care declared:

"It indicates, in our opinion, that the answer to our health-care plight is not only finding a way to pay the bills, but revamping the structure, and perhaps realigning professional values, as well."

* * *

Heard a provocative talk by Hugh McCahey, Manager, Association Dept., Chamber of Commerce of the USA, before the Detroit Association Executives, recently. Following are some of his observations, challenges, etc.:

Associations must move toward smaller boards, to task-force committees and fewer standing committees. Standing committees tend to waste the time of staff members, and waste money . . .

Associations should help schools with technical training because we all face great shortages in skilled personnel . . .

The consumer revolution is just beginning . . .

Most associations have much research in their file cabinets that would help legislative aides, etc. . .

Intelligent grassroot support is essential . . .

More business and professional people must get involved in political support efforts. Money must be given to help candidates.

* * *

The headline writer at the Benton Harbor *News Paladium* had fun with a headline on an Ann Landers column recently:

BRA-LESS FAD A FLOP

* * *

"For the U.S. Post Office, it was not exactly a vintage year. Users of mail continually grumbled about slow and unreliable service. There were complaints about high postage rates. Expenditures exceeded revenues, producing a deficit in the postal operation. . . ."

So said Samuel Osgood, the postmaster — back in 1789.

* * *

The 1969 Annual Report of the Kellogg Foundation, recently published, includes a photograph of the Michigan Health Council's Health Careers Mobile. The booklet of the Kellogg Foundation, which helps support the Health Council career efforts, states in part: "The exhibits van is but one of many devices used by the Michigan Health Council in its development of a health careers recruitment program over the state. A belief of the Foundation-aided Council is that a coordinated state program will be more effective than the efforts of individual agencies and professional groups to meet current and future health manpower requirements.

* * *

"Policy-making Positions Open" advertises the Norfold District Medical Society at Boston. The notice to the Society members states: "Open from time to time are positions for physicians interested in participating in policy making for the physicians of the Commonwealth of Massachusetts.

"Although previous organizational experience is not needed, preference will be given to those who have demonstrated interest in legislative activities. Duties will require approximately 50 hours a year. Rewards are intangible. Advancement to more responsible duties are available. An equal opportunity employer."

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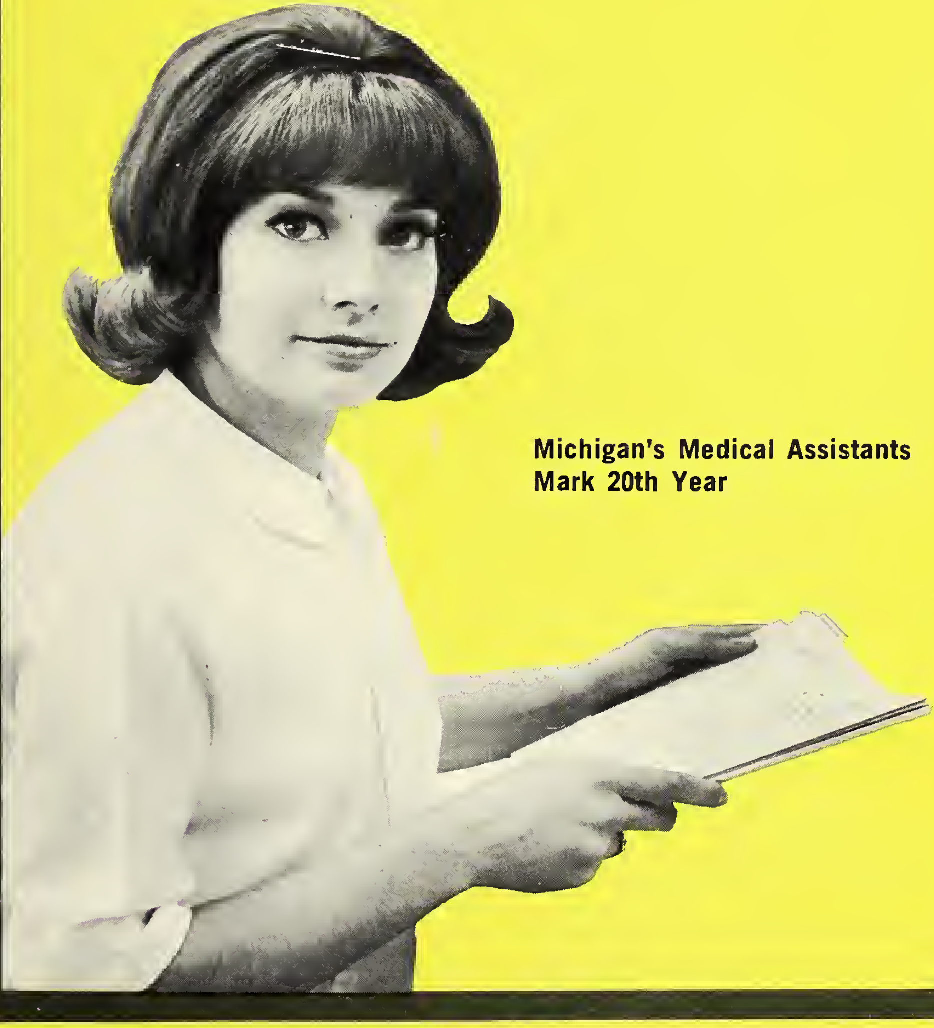
Better Continuing Medical Education
Doctor Mason Visits County Societies



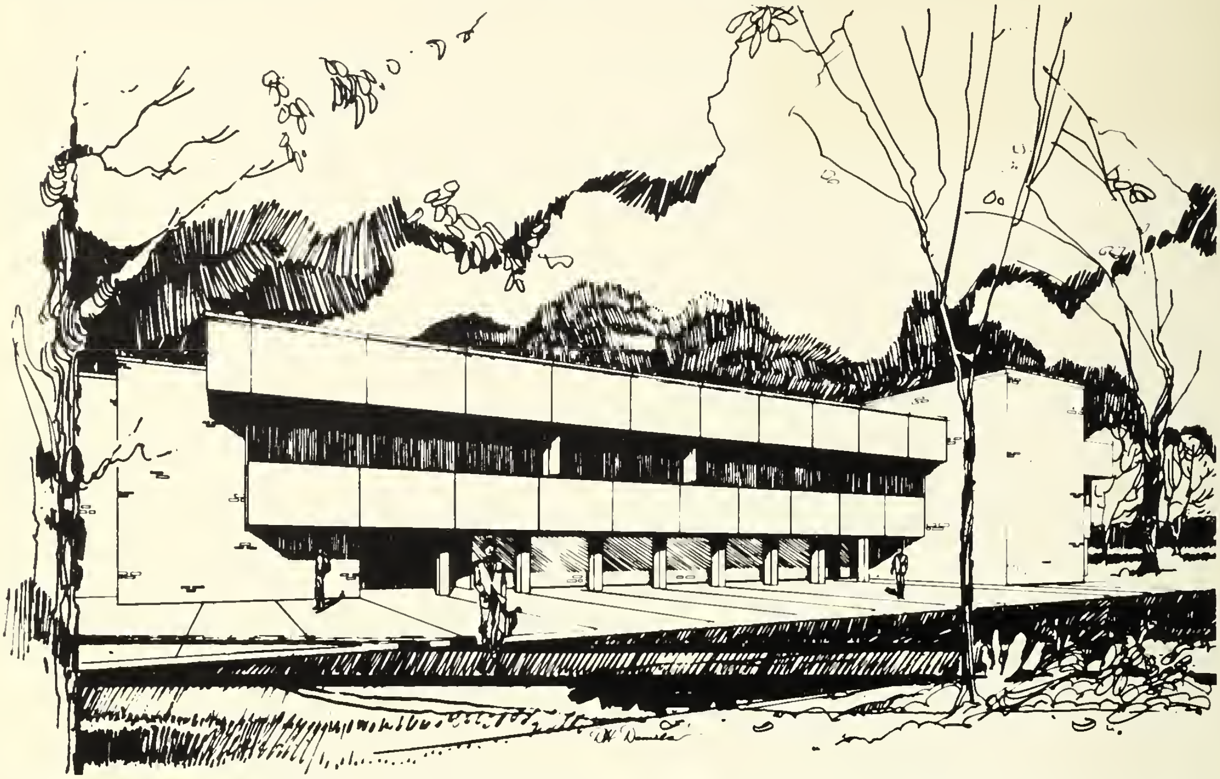
**Michigan's Medical Assistants
Mark 20th Year**

MSMS 1970 Annual Session Sept. 20-24, Detroit

**Michigan State Medical Society
June 1970, Volume 69, Number 11**

DRUG ABUSE...

INTERNATIONAL SYMPOSIUM For PHYSICIANS



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November 9-13, 1970

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. . . the complete spectrum of drug abuse: medical, pharmacologic, psychiatric, legal, social and philosophic . . .

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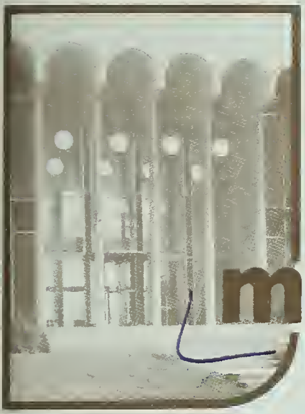

Breaking News: Deadline May 8
May 1970, Volume 69, Number 10
Michigan State Medical Society

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Progress Report on Key Medical Legislation; Volunteer Physician Representatives Continue to Serve

"The MSMS volunteer physician representatives" are continuing to spend a week each at the Capitol Building in Lansing under the unique MSMS plan to provide a physician as resource to state legislators.

Physicians lined up for the remainder of the spring session are Frederick W. Bryant, M.D., Royal Oak, the week of May 18; Mahlon S. Sharp, M.D., Lansing, May 25; Keith M. Holmes, M.D., Pontiac, June 1, and Edwin M. Knights, Jr., M.D., Southfield, June 8.

Key legislative items of concern to the physicians and the status of the bills as of May 5, include:

SB 1312—Would exempt from subpoena the records of "Peer Review" committees. Passed by the Senate with a vote of 32-0, it proceeded to the House Committee on Public Health. It is supported by MSMS.

HB 4059—Would exempt U.S. trained M.D.s and D.O.s from the Basic Science Laws. Passed by the House 89-7, it proceeded to the Senate Committee on Health Social Services and Retirement. Also supported by MSMS.

HB 3214—Would increase annual registration for M.D.'s fees from $5 to $25 (as reported from committee). In House.

HB 4384—Would require physicians to accept uniform fees for Medicaid, with said fees not to exceed those paid for service rendered under Title XVII (Medicare). In House Committee on Social Services and Corrections.

HB 4627 and 4628—Would increase the boards of Blue Cross and Blue Shield to 25 members each with only three M.D.s, to be appointed by the governor. In House Committee on Insurance, which called a public hearing on the bill May 4 in Southfield.

SB 1314—Would add lay members to State Board of Podiatry. In Senate.

SB 1440—Would add five non-physician members to the State Board of Registration in Medicine, thus increasing the Board from 10 to 15 members. In Senate Committee on State Affairs.

Special Executive Session of Council Called May 26

A special executive session of The Council has been called for 8 p.m. Tuesday, May 26, to receive the report of the Alexander Grant Company's study of the management of MSMS.

It is hoped that there will be 100 percent attendance of The Council at the meeting, which will be held the evening before the regular Council meeting on May 27.

Doctor Yudashkin Appointed Acting Director of Mental Health Department

Dr. Yudashkin

E. Gordon Yudashkin, M.D., Lakeland, will assume duties June 30 as acting director of the Michigan Department of Mental Health. He was appointed early in May by Gov. William G. Milliken.

Doctor Yudashkin, who since May, 1969, has been director of the department's Division of Community and Hospital Services for the Mentally Ill, will take the place of William H. Anderson, M.D., who submitted his resignation April 8. Doctor Anderson had made no announcement of his future plans at deadline for this publication.

Third Base Rate Rise This Year Boosts Blue Shield Rates 16 Percent

Starting with contracts renewed July 1, Michigan Blue Shield medical insurance contract base rates will rise 16 percent.

State Insurance Commissioner Russell E. Van Hooser on May 1 authorized Blue Shield to boost its base rates for the third time this year and at the same time approved a 3.8 percent increase in the base rates for Michigan Blue Cross hospitalization policies.

Blue Cross rates have gone up nearly 40 percent since January, 1968, and Blue Shield rates have increased 43 percent in the last year. When the higher rates are fully reflected, income of the two insurance corporations will be increased about $46 million annually.

Umbrella Liability Insurance Policies Now Available To MSMS Members

The MSMS Personal Prestige Policy of "umbrella coverage" for professional liability is now available to MSMS members after a delay of several months to clear details with the Michigan Insurance Commissioner.

The Council and the MSMS Committee on Professional Insurance Plans recommend this new sponsored plan, specifically designed for physicians.

It will provide excess liability coverage above basic insurance in amounts of $1,000,000 to $5,000,000. It will apply to all insured exposures such as professional or malpractice, office premises, automobile and residence. It will also cover usually-uninsured items such as libel, slander and invasion of privacy.

The administrator is the Ben P. Stratton Agency, Inc., with offices in Lansing and Southfield. Further details will follow in *Michigan Medicine.*

Upper Peninsula Medical Society Meeting June 18-19 Schedules Seven Out-of-State Speakers

Seven out-of-state speakers will lead the faculty for the 75th annual meeting of the Upper Peninsula Medical Society June 18-19 at the Ojibway Motor Hotel in Sault Ste. Marie.

Scientific meetings are scheduled all day Friday, June 18, and throughout the morning of Saturday, June 19. Saturday afternoon is

"For Meritorious Service in The Battle of Capitol Hill, Lansing, 1970 Campaign," William A. DeYoung, M.D., Saginaw, right, receives a certificate of appreciation from MSMS. Two of the certificates, which will be presented to each MSMS volunteer physician representative to serve as a resource to the Michigan legislature in Lansing for one week, were awarded by Otto K. Engelke, M.D., left, chairman, at a recent meeting of the MSMS Legal Affairs Committee.

IN ADDITION TO his certificate "for meritorious service," each volunteer physician representative for MSMS receives a service bar resembling those worn by veterans of military battles. R. J. Huebner, M.D., Hastings, right, wears his as he receives his certificate from Doctor Engelke. Doctor Huebner was the first physician to spend a week at the Capitol. The bars are decorated with red, white and blue, signifying good citizenship, "black and blue together with reasons obvious upon reflection," and purple for valor.

traditionally left free for sightseeing, recreation and family activities by the Upper Peninsula society.

Out-of-state speakers and their topics include John J. Juergens, M.D., of the Clinical Section of Mayo Clinic, "Management of Hyperlipidemia;" Alexander Schirger, M.D., Associate Professor in Clinical Medicine, Mayo Graduate School, "Management of Hypertension;" Robert L. Tygart, M.D., Duluth, Minn., "Pulmonary Contusions;" Donald C. McIlrath, M.D., head of Section of Surgery, Mayo Clinic, "Management of the Patient with Acute Gastrointestinal Bleeding;" Paul Kowalishin, M.D., C.M., C.R.C.S., Sault Ste. Marie, Ontario, Can.; "Some Interesting Urological Cases;" James E. Gleichert, M.D., F.A.C.S., North Chicago, Ill., Obstetrical Eponyms;" and Michael Scarf, M.D., Sault Ste. Marie, Ontario, Can., "Nuclear Medicine."

MSMS House of Delegates Committees At Work on 1970 Annual Session

James B. Blodgett, M.D., Royal Oak, speaker of the MSMS House of Delegates, has announced that all House of Delegates committees are at work preparing for the 1970 MSMS Annual Session.

The five-day meeting is scheduled Sept. 20-24 at the Sheraton-Cadillac Hotel, Detroit. The House of Delegates will convene Sunday night, Sept. 20, and continue in session all day Monday and Tuesday. The Annual Scientific Session then will follow on Wednesday and Thursday, Sept. 23 and 24.

Chairmen of the House of Delegates committees who are planning the three-day session include John J. Coury, M.D., Port Huron, Compensation of Officers; H. Ross Hume, Jr., M.D., Detroit, Certificates of Commendation; Noyes L. Avery, M.D., Grand Rapids, Proceedings of the

House of Delegates and Paul R. Dumke, M.D., Detroit, Constitution and Bylaws.

The new House of Delegates committees include one on the Nominating Processes of the House, chaired by Donald N. Sweeny, Jr., M.D., Detroit, and one on the Relationship of Specialty Societies, led by Frederick C. O'Dell, Jr., M.D., Alpena.

Hearing Held Re MMS-MHS Boards

Letters were sent late in April from MSMS headquarters to medical leaders in Wayne and Oakland counties urging them to attend a public hearing May 4 in Southfield.

Subject of the meeting, called by the Michigan House of Representatives Insurance Committee, was a pair of bills pending in the House to put the boards of Blue Shield and Blue Cross under public control.

MSMS did not officially testify, but the MSMS Committee on Legal Affairs and MSMS Council have informed the House of Representatives Committee that MSMS opposes the bills. Among those testifying May 4 were representatives of the Michigan Insurance Bureau, Michigan Medical Service, labor unions, and concerned individuals.

MSMS Maternal Health Committee To Meet May 22-23 at Gull Lake

Ted Ervin, director of the Bureau of Management Services of the Michigan Department of Public Health, will discuss the use of the computer in perinatal statistics at the Gull Lake Meeting of the Committee on Maternal Health this month.

Also at the May 22-23 meeting at the Kellogg Biological Station, the committee will hear reports from its subcommittee chairmen. They include Laurence Bruggers, M.D., Saginaw, who will report on the Detroit Maternal and Infant Care Project; Charles S. Stevenson, M.D., Detroit, who will present the maternal death statistics; Jack R. Postle, M.D., Petoskey, who will present the perinatal morbidity and mortality statistics; Richard T. Mellis, M.D., Kalamazoo, who will report on the lay education subcommittee, and Darrell Statzer, M.D., Detroit, who will discuss "The Increasing Post-Partum and Intra-Partum Care of Detroit's City Physician Patients."

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MICHIGAN STATE MEDICAL SOCIETY

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Breaking News: Deadline May 26
June 1970, Volume 69, Number 11
Michigan State Medical Society

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Federal Closed Panel Medical Group Proposal Tops Rundown of Recent Legislative Action

Much legislative action at state and federal levels is currently of high interest to Michigan physicians.

A bill of great import is currently under consideration in Washington that would allow individuals eligible for Medicare benefits to choose to have their care provided by a health maintenance organization or closed panel medical group.

The federal bill, called the administration's "health maintenance option," was proposed by HEW, passed by the U. S. House Ways and Means Committee, and was expected to pass the House by the end of May.

This so-called "health maintenance option" authorizes government to contract with pre-paid plans and others to combine Parts A and B of Medicare and offer these benefits on a prepaid basis to elderly beneficiaries at 95 percent of average cost to government.

The bill also limits physician reimbursement under Medicare to the 75th percentile, restrains future increases according to a cost-of-living index, and gives HEW the power to dismiss from the program physicians and hospitals who abuse Medicare.

Meanwhile, back in Michigan, the Michigan House has passed the amendment to the Basic Science Law. The bill, HB 4059, as of May 26 was in the Senate Health, Social Services and Retirement Committee.

The bill, as passed by the House, would change the act so that it no longer applies "to any person legally registered and licensed to practice healing . . . nor to any person graduated from an accredited medical or osteopathic college located within the United States." The act still applies to graduate students of foreign, including Canadian, medical schools.

MSMS has long supported an amendment to repeal this law, but lacking repeal, supports the amendment described above.

Another important state bill is HB 3214, which would increase the annual registration for M.D. fees from $5 to $25. The House defeated the amendment to increase the fees and re-referred it to the appropriations committee.

Abortion law reform, supported by MSMS, is virtually dead for this session, although proponents of reform in the legislature vow to keep the issue alive.

Another bill, sponsored by MSMS, would protect all records of peer review committees from subpoena. Entitled SB 1312, it has passed the Senate, 32-0, and on May 26 was in the House Committee on Public Health.

A bill with some implications for all professional licensing boards in Michigan is SB 1314. It would make many changes in the present podiatry licensing law, including increasing the podiatry licensing board from

THE MSMS EFFORTS to elect Otto K. Engelke, M.D., right, MSMS past president and legal affairs committee chairman, as the vice-president of the AMA are being advanced by the MSMS delegation to the AMA, Donald W. Sweeny, Jr., M.D., chairman. Shown at an MSMS conference at the speakers table with Doctor Engelke is E. B. Howard, M.D., executive vice president of the AMA.

MSMS
ERNEST B.
OTTO K.
ENGELKE, M

RECENT LEGISLATIVE ACTION/Continued

three to five members, one of whom could not be a podiatrist. The bill was re-referred to the appropriations committee on May 18.

Michigan physicians who would like a more detailed rundown on current medical-related legislation may contact MSMS headquarters.

Doctor Steffe Heads Michigan Ob/Gyn Society

Ralph Steffe, M.D., Flint, is new president of the Michigan Society of Obstetricians and Gynecology. He was installed at the group's annual meeting in Detroit May 5.

New officers elected to lead the society are Lee B. Stevenson, M.D., Detroit, president-elect; John M. Malone, M.D., Detroit, treasurer, and Joseph Woods, M.D., Ypsilanti, secretary.

New MSOBG council members are Robert E. Bogue, M.D., Southfield; Laurel S. Eno, M.D., Detroit; William Jack, M.D., Grand Rapids; Eli J. Igna, M.D., Detroit; Jack W. Thompson, M.D., Flint; Darrell E. Statzer, M.D., Detroit; Robert Walkowiak, M.D., Detroit; George Morley, M.D., Dearborn, and Harrison C. Visscher, M.D., Grand Rapids.

Coller-Penberthy-Thirlby Conference July 30 and 31 To Present Following Out-of-State Speakers

Nine out-of-state speakers will be featured participants in the 50th annual Coller-Penberthy-Thirlby Medical Conference July 30 and 31 at the Park Place Motor Hotel, Traverse City.

Among those secured by program chairman James French, M.D., chairman of the Department of Pathology at the University of Michigan Medical Center, and their topics, are:

J. Garrott Allen, M.D., chairman, Department of Surgery, Stanford University School of Medicine, "Voluntary Blood for Everyone"; Allan C. Barnes, M.D., director, Department of Obstetrics and Gynecology, Johns Hopkins University School of Medicine, "Social Responsibility"; George D. Zuidema, M.D., director, Department of Surgery, Johns Hopkins University School of Medicine, "Selective Management of Penetrating Wounds of the Abdomen," and Paul H. Jordan, Jr., M.D., professor of surgery, Baylor College of Medicine, "A Prospective Evaluation of Vagotomy-Pyloroplasty Versus Vagotomy Anthrectomy and Gastroduodenostomy for Treatment of Duodenal Ulcer."

Further details will follow in the June *News Extra.*

Annual Session PG Courses Have Broad Appeal

The all-day postgraduate courses at the 1970 MSMS Scientific Session Sept. 23 and 24 promise to be "a good show," says Scott Swisher, M.D., East Lansing, chairman of the PG courses. With broad topics — Hypertension, and Clinical Pharmacology and Therapeutics on Sept. 23; Allergy, and Shock-Blood Fluids and Electrolytes on Sept. 24 — the four 1970 PG courses are carefully designed to meet the practitioner's needs. Audience participation will be emphasized, says Doctor Swisher. Each course is scheduled from 8 a.m. to 5 p.m. at the Howard Johnson Motor Hotel, across the street from MSMS Annual Session Headquarters at the Sheraton-Cadillac Hotel in Detroit.

Doctor Swisher

Upper Peninsula Medical Society Schedules 75th Annual Meeting June 19-20

The schedule has been completed for the 75th annual meeting of the Upper Peninsula Medical Society June 19 and 20 at the Ojibway Motor Hotel, Sault Ste. Marie.

Registration will begin at 8 a.m. both days. On Friday, June 19, a welcome will follow by W. F. Mertaugh, M.D., U.P. Medical Society president. Earl Sid Rhind, Jr., M.D., U.P. Society secretary, will give a luncheon talk Friday noon, and a dinner dance is scheduled Friday evening. Saturday afternoon will be free.

MSMS President Robert J. Mason, M.D., Birmingham, will officially represent the state society at the meeting.

Friday morning's discussions will be of Hemotoxic Drug Reactions, Hyperlipidemia, Hypertension and Pulmonary Contusions. Friday afternoon talks will be about Injuries of Peripheral Nerves, The Patient with Acute Gastrointestinal Bleeding, Surgical Management of the Infertile Patient and The Acute Abdomen. The meetings Saturday morning will take up Some Interesting Urological Cases, Obstetrical Eponyms, Nuclear Medicine and Brain Complications in Children.

Genesee County Medical Society Co-defendant In Civil Suit Over Measles Inoculation

The Genesee County Medical Society has filed an answer in Genesee County Circuit Court to charges in a $250,000 suit brought against it and several co-defendants by the parents of a Mt. Morris boy.

The boy, then 11, was inoculated April 23, 1967 in an "end the measles" campaign and two months later lapsed into a coma, suffering from encephalitis. The suit claims that he has been, since that time, "totally and completely mentally retarded."

No dates have been set in the trial. Other defendants are the Mt. Morris Consolidated School District, the Dow Chemical Co., the Pitman-Moore Co., Inc., the Genesee County Health Department and "end the measles campaign" personnel.

Capsules

MSMS President Robert J. Mason, M.D., Birmingham, is one of three speakers who will present a short devotional talk at a Sunday Interfaith Prayer Breakfast during the AMA Convention June 21-25 in Chicago. Doctor Mason will be representing state medical societies.

ANNIVERSARY CAKE centered, nine past presidents of the state medical assistants society gather during special ceremonies marking their 20th year at their annual convention in Detroit. From left are Mrs. Betty Lou Willey, Port Huron, president in 1960-61; Mrs. Dorothy Brandis, Lansing, 1963-64; Mrs. Mary Jordan, Eaton Rapids, 1968-70; Mrs. Elizabeth Peck, Detroit, 1953-54; Miss Marlouise Redman, Detroit, 1957-58; Miss Phyllis Marquardt, R.N., C.M.A., Kalamazoo, 1964-65; Mrs. Alta Greene, Battle Creek, 1966-67; Mrs. Juanita Ferman, Jackson, 1965-66, and Mrs. Nelda Gasperson, C.M.A., Mt. Clemens, 1967-68.

A SPECIAL APPEARANCE was made at the Michigan medical assistants' 30th convention at the Pontchartrain Hotel, Detroit, by Robert J. Mason, M.D., left, MSMS president. He met with, from left, Mrs. Betty Lou Willey, Port Huron, speaker of the House of Delegates of the national medical assistants, Mrs. Isabelle Stevenson, convention programmer and president of the host Wayne County society, and John W. Derr, M.D., a convention speaker.

TOP OFFICERS, newly elected by the State of Michigan chapter of the American Association of Medical Assistants, share an informal moment at their recent 20th annual convention with their close friend and advisor, Glenn E. Millard, M.D., Detroit. From left are Miss Margaret, Broadwell, Detroit, vice president; Mrs. Betty Boers, Kalamazoo, president-elect, and Mrs. Patricia Austin, Ann Arbor, president.

Allen Park VA Hospital Granted Approval for Two New Units

Approval for completion of an eight-bed medical intensive care unit and a five-bed coronary care unit has been granted to the Allen Park Veterans Administration Hospital.

Money for the projects ($278,000 is the target cost allowance for the two units) will come later, according to Milton R. Weed, M.D., chief of staff. The building schedule calls for the new units to be open for operation by June 1, 1971.

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No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

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Intestinal monilial overgrowth has appeared this week

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Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

IN THIS ISSUE

The photograph on this month's cover is provided by the AMA and marks the 20th anniversary of the State of Michigan chapter, American Association of Medical Assistants. An editorial on page 538 also commends the medical assistants on their 20 years of service to Michigan's physicians, while pictures in the breaking news pages present high points of their recent 20th anniversary convention in Detroit. We salute Michigan's medical assistants.

SCIENTIFIC ARTICLES

479 The Risks in Intracranial Obliteration of Berry Aneurysms; Harvey Gass, M.D.
485 A Case of Human Pesticide Poisoning; W. A. Gilpin, M.D.
489 Initial Experiences with Fathers in the Delivery Room; Charles W. Aldridge, Jr., M.D.
493 Midline Lethal Granuloma Complicated by Thrombocytopenia and Pancreatitis; B. Gandhi, M.D., G. Bazil, M.D., L. Kuran, M.D., A. Olson, M.D.

SPECIAL ARTICLES

522 Physicians Urged to Fight for Environmental Quality
530 Physicians Urged to Help in Statewide Survey of Handicapped Children; Judith Marr

OTHER FEATURES

463 breaking news
470 county societies
472 msms leadership
473 officers' page
474 your opinion please
492 the viewbox
monthly surveillance report
500 msms news
mediscene
501 council minutes
511 medical care programs
520 socio economics
531 mailbag
536 about doctors
538 editorial viewpoints
540 in memoriam
544 noted and quoted

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Bay Physicians Protest Blue Shield Letter To GM Employees

(MSMS Council Chairman Ross V. Taylor, M.D., Jackson, recently received the following letter from the secretary-treasurer of the Bay County Medical Society, John W. Grigg, M.D., Bay City.)

Dear Doctor Taylor:

The Executive Committee of the Bay-Arenac-Iosco County Medical Society wishes to bring to the attention of the Michigan State Medical Society Council two enclosed items.

1. A notice furnished by the Michigan Blue Shield for distribution to General Motors Division employees.

2. A copy of the directive from the General Motors' Management to its divisions.

The intent of the two underlined sentences we believe is an attempt by Michigan Blue Shield to coerce non-participating physicians and has special significance respective to a letter from Michigan Blue Shield, March 25, 1970. "2. Selective adjustments in prevailing screen levels." We interpret this to mean there will in certain instances be a decrease in Blue Shield's interpretation of the usual, reasonable, and prevailing fee. Since Blue Shield has made no statement which procedures will have adjusted levels, a physician with a fee schedule, with overhead expenses which cannot be reduced, has only one recourse to prevent being caught in the squeeze, NON-PARTICIPATION. This is not imaginative concern. In the past three weeks, patients in our area have vigorously objected to signing the acknowledgment on the Blue Shield form.

Blue Shield's actions are especially objectionable for there has been no attempt to publicize to the consumer Blue Shield's reduction of fees. We further believe without Blue Shield's public acknowledgment of a fee decrease, patients will in essence believe physicians have actually increased fees. Our public relations have (from recent newspaper editorials) suffered. We do not believe it will be enhanced by Blue Shield's latest maneuver.

Abortion Law Reform Favored by Two County Societies

Members of the Washtenaw and Genesee County Medical Societies have released position papers on abortion law reform, a major issue before the Michigan legislature in this session.

The Washtenaw Society was the first county medical society in the state to do so. Its action was prompted by a request from Sen. Gilbert E. Bursley of Ann Arbor that the doctors reveal their position on abortion law reform.

The basic message of the Washtenaw position paper was that the question of abortion should be a matter between the woman and her physician, according to George H. Koepke, M.D., Ann Arbor, president. A second part of the paper also favored removal of the abortion law from the penal code to the medical practice act.

Copies were sent to each state legislator from the Washtenaw County area and to the governor.

The Genesee County Medical Society gave qualified support to liberalization of the state's abortion laws at its March 5 business meeting. Copies of its paper were sent to MSMS, Genesee County legislators and Sen. Lorraine Beebe, chairman of the Senate Health, Social Services and Retirement committee.

The Genesee County society's majority report supports Senate Bill 288, which would allow abortions to be performed by any physician in a licensed Michigan hospital, with the decision left solely to the physician and his patient.

The Genesee minority report "recognizes the rights of others to solve problems in their own way," but presents the opinion of those county society members who are against the philosophy of abortion.

Genesee Physicians Meet with Clergy

Members of the Genesee County Medical Society sponsored their second annual Medical-Clergy Dinner recently at the Mott Children's Health Center in Flint. Guest speaker was Granger E. Westberg, professor and director of continuing education at the Hamma School of Theology, Wittenberg University. Invitations were sent to more than 350 area clergymen to hear Doctor Westberg, who was also speaker at the MSMS-Wayne County Medical Society sponsored Medicine and Religion Workshop the same day in Detroit.

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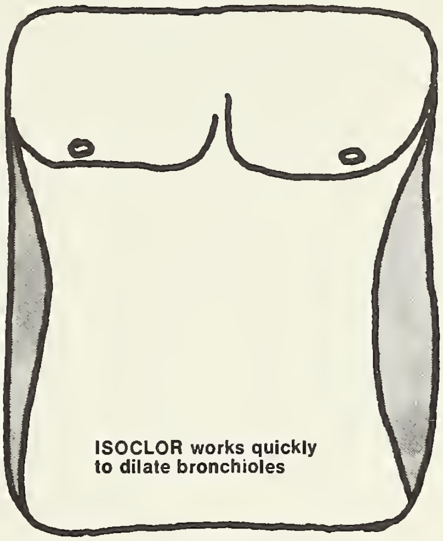

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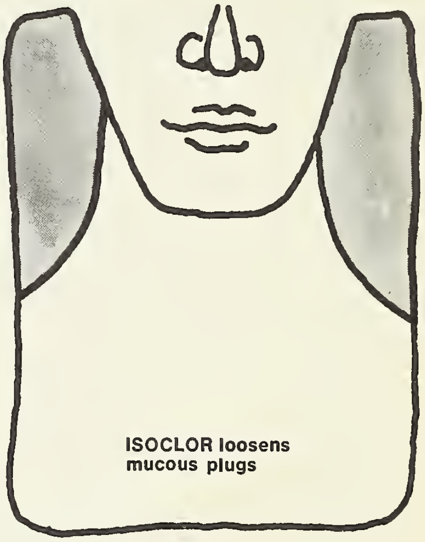

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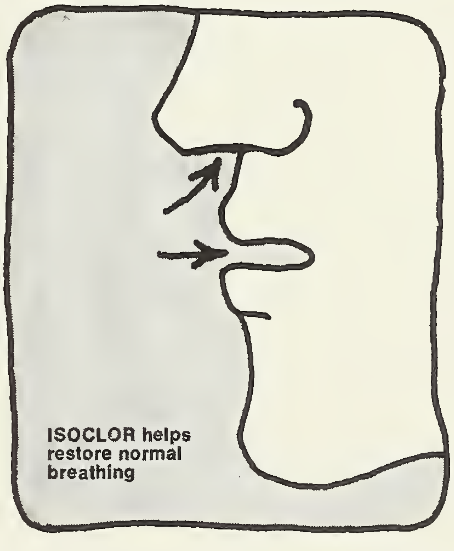

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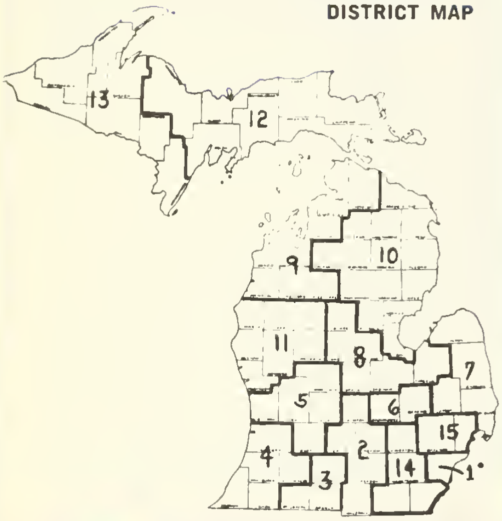

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MSMS A Pacemaker; Dedicated "To the Unfinished Work"

This spring I had the opportunity to visit the annual meetings of several of the other state medical societies in the midwest.

Such visitations always provide the opportunity to compare our own MSMS with the other state medical societies, and I can assure you that we have one of the very best in the nation!

Let me comment on several of the special reasons why I am especially proud of MSMS at this time.

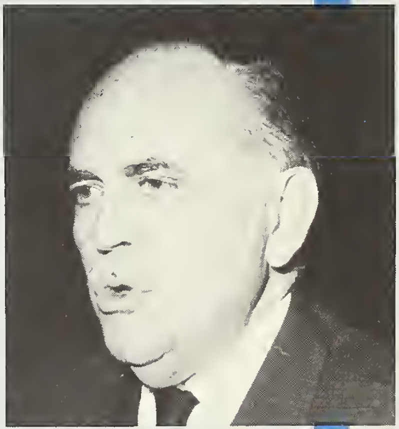
Our MSMS House of Delegates certainly is a pacemaker. I doubt if any other House considers such a large number of carefully-developed resolutions as the Michigan delegates. The Michigan delegates work mighty hard and deal with vital issues.

The scientific program at our Annual Session, too, rates as really outstanding. Most states offer only one didactic lecture after another throughout the day, while MSMS presents panel discussions, debates, etc., with a choice of three or four concurrent sessions throughout the day.

Few of the state medical societies are as aggressively examining their own operations. All medical societies today face new challenges on many social and medical fronts and the other states are interested in the work of our new MSMS Council Committee on Priorities and Planning, and our new Task Force on MSMS Structure. The Task Force Committee met May 19 to receive the report of Phase I study by the Alexander Grant and Company.

Few of the states are dealing with the critical issues facing all of us on the delivery of health care. For example, our MSMS Education Liaison Committee is working with Western Michigan University on the possible development of a four-year curriculum to train "assistant physicians." Our Committee on Medical Socio-Economics is considering whether MSMS should apply for a federal grant to operate a multi-phasic screening program as a pilot, research project. Our Committee on Postgraduate Medical Education is making a study toward "the possible establishment of minimum standards for continuing medical education as a requirement for membership in MSMS or for continued reregistration in Michigan." I have told other states about the work of many other committees all being aided by our competent MSMS staff members.

You can be sure that I took advantage of the opportunities at these other state medical society meetings to blow our MSMS horn, too, about the "MSMS Volunteer Physician Representatives program" to the Michigan legislature; about our continuing efforts to expand the three Michigan medical schools; about our progressive stands on the teaching of sex education, on abortion, on maternal health research studies, etc., etc.



Robt. J. Mason, M.D.
MSMS President

MSMS members should be proud of their state medical society. It can be made even more effective if individual physicians, if the component medical societies, if MSMS committees, et al, accept the challenge of Abraham Lincoln:

"It is for the living . . . to be dedicated to the unfinished work."

your opinion please

Do you believe the medical profession is successfully meeting its professional obligations in providing opportunities for continuing medical education? How could the medical profession further meet its responsibilities?

Robert L. Tupper, M.D.
Pontiac

I do not believe that the medical profession is adequately meeting its obligations in the field of continuing medical education. The wording of the question, Are we successful in providing opportunities? I think points out our major problem. I would suggest that we have an overabundance of opportunities, but inadequate education. We have done well to come this far in the 60's — the era of creating opportunities — but it it now time to leave our current plateau and take the next step of the 70's — creating *effective* continuing medical education.

I think our goal in continuing medical education should be to help a physician continuously improve the quality of care he delivers to his patients. In other words, continuing medical education should equate with improved performance.

Today we make no significant attempt to determine what types of continuing education physicians really need. I would suggest that many of our classical lectures on rare exotic states, viewed in terms of real value, are total wastes. In today's world, we choose subjects for conferences on the basis of (1) what is new; (2) what the instructors want to talk about; (3) what will draw a crowd. We do not even know what is needed by either a group of physicians or by individual physicians in terms of improving performance.

Against this background, one trend seems clear. This is the emergence of the hospital medical staff and its departments as the functional unit in everyday continuing medical education. This is coincidentally the only level at which we can evaluate performance as opposed to simple knowledge. A system to accomplish this exists, but we do not utilize it as such.

I would suggest that each department of the medical staff should have an active audit committee. This committee should meet regularly and not simply review random charts, but rather it should ask itself specific questions with regards to the quality of care furnished by the staff for specific problems. A selective review of charts looking for these answers will then, in fact, create a profile showing problem areas where performance needs improvement, either by individuals or by departments. If we can then structure hospital conferences so that they can impact on some of these problem areas, or tactfully direct a man towards existing courses that may strengthen his abilities, then the result might be the delivery of improved medical care.

I would further suggest that in follow-up, the audit committee could look at these same problems and determine whether a particular educational effort had indeed produced improved performance. If it had not, then I would suggest that particular educational opportunity was a waste of time and money.

Our emphasis should be on improved performance, not on opportunities; on whether we really make a difference, not on measures of exposure; on what the physician has demonstrated he needs, not necessarily on what he wants. When we finally arrive at the point where continuing education really makes a difference, then we will be adequately meeting our obligation.

Douglass A. Haddock, M.D.
Kalamazoo

The practicing physician after his many years of medical school and hospital training must by necessity look forward to a never-ending need for continuing education. In large communities located in the southern half of Michigan much of this educational requirement can be met by well-designed hospital meetings including medical, surgical, pediatric, OB-gynecological conferences and clinical pathological conferences.

Other sources of information at close hand are the numerous meetings sponsored by the Michigan State Medical Society, Michigan Academy of General Practice and specialty groups. The University of Michigan and Wayne State University provide excellent courses for eager physicians. *Audio Digest* and the new A.M.A. *Audio News Journal* provide excellent sources of information via tapes that can be enjoyed in our cars, homes or offices. Medical books and journals in abundance round out the prodigious sources of medical knowledge available to us.

Where do we fail in this serious matter of providing continuing medical education? I believe that the doctor in the small community, far from a large hospital and from the usual sites of meetings suffers the most. A small hospital with few members on the staff has a difficult time producing meaningful regular educational seminars. Many physicians in outlying areas have difficulty getting away from their large practices due to inadequate coverage.

One or two day seminars scattered throughout the state would be very helpful for those harried men. A one-hour lecture several times per year is next to useless. Several proposed meetings during the coming summer by the University of Michigan and the Michigan Academy of General Practice at a northern resort location are a step in the right direction. The Michigan State Medical Society should also explore this area and plan meaningful regional seminars in the future.

Another excellent project would be a tape library available by telephone to any M.S.M.S. member. The most recent dissertations on common medical problems could be kept stored in this library at M.S.M.S. headquarters. Upon phone request tapes could be played for the caller at any hour providing necessary timely information on diagnosis and treatment.

Thank you for the opportunity to present my views on this all important subject.

James A. Amlicke, M.D.
Battle Creek

Today's physician finds himself challenged by an ever-increasing patient load, teacher responsibilities, and the continuous job of updating his knowledge in his chosen field through attendance at local, state and national meetings. However, too many doctors do not adequately support the educational needs of their medical communities and usually provide the well-worn excuse that "the practice ties me down." The pathos of it all is that the physician gets so wrapped up in his practice that he forgets the teaching value of some of his case material and experiences. A breakdown in communication with his colleagues along these lines leads to complacency, poor attendance at local teaching sessions, and ultimately medical mediocrity.

A progressive and innovative medical community exists only when the individual physicians are concerned enough about the needs of their community rather than just the needs of patients. Young, well-trained physicians are looking for such a medically dynamic town. Medical leadership in this town must prevail before it can be considered a progressive one.

THE PHYSICIAN can channel his activities in many ways in attempting to promote continuing medical education. He can participate on planning committees at local colleges which are establishing courses for para-medical services. He can help organize health career day activities to stimulate the interest of high schoolers in medical programs as careers. Other areas where his services are vitally needed include:

1. participation in intraining programs for nurses (LPN's as well);
2. encouraging periodic educational sessions locally in his own specialty, inviting colleagues from neighboring cities as well;
3. holding clinical pathological conferences every month and by so doing, helping to check a faltering peer review system, and
4. establishment of comprehensive, well organized programs in coronary, pulmonary, cancer and amputee care.

A co-ordinated effort between a smaller medical community and a university with medical school and residency training programs would be very beneficial to both medical students and interns

Revolutionizing The Health Care System

This month *Michigan Medicine* continues its special section, "your opinion please," to present the views of Michigan physicians on vital issues. The feature was interrupted in the May issue to allow space for special articles highlighting Michigan and Hospital Weeks.

Your comments are invited in response to the question asked on this page. Each month a question will be selected and interested physicians will be urged to send in their reactions.

The August question will be: "Suggest at least one way in which you believe the health care system could revolutionize itself to become more responsive to the health needs of a rapidly evolving system."

from the university. Participation in externships at the affiliated city hospitals will compliment their strong programs. The other advantages to such university tie-ins are numerous and obvious.

The medical community which pursues these aforementioned activities and goals will not be wanting for lack of young physicians. The learning process does not terminate at the completion of internship or residency programs and must be relentlessly pursued by any who claim to have a sincere interest in the profession and in the future of the community.

L. L. Loder, M.D.
Muskegon

In answer to your question, I find myself rather frustrated, for continuing education starts after the medical degree.

Certainly the medical profession in the teaching institutions, in preparing the graduate for general practice in internship, and continued training for any of the specialties in residencies, is excellent.

Upon completion of training, each specialty has its academy of post graduate instruction to keep abreast of progress. The AMA has its sectional meetings at various places over the country for general and specialized post graduate studies. The state society has its annual meeting with scientific program as does the county monthly meeting. Then there are the biannual post graduate lectures, seminars or panel discussions made available by the Department of Postgraduate Studies at the U of M—headed by Doctor Towsley and using the Wayne and U of M faculties as resource teachers.

This is the program I've been associated with for so many years for Muskegon. This brings help on any medical topic to the local city level where problems exist. The university makes other lecture series available.

At the hospital level, each department — surgery, general practice, obstetrics, internal medicine — has monthly meetings as do many of the subspecialties, where death reviews and a scientific program are presented and discussed. Each of our two hospitals has its general staff meeting where a medical program is given plus hospital business.

It seems to me that so far as dissemination of new medical discoveries, ideas and techniques are concerned, the medical profession, in its teaching, its meetings and its journals, is doing a very satisfactory job in meeting its obligation to bring the best medical care possible to the sick patient. And also in taking up most of the doctors' non-practicing time in doing it.

I think we as doctors are weak in recognizing and coping with the new, yet old, third party — government — in medicine, which constantly forces its way between the doctor and patient and dictates so much, that the doctor finds himself being told how he should treat his patient. Medicine's most important extracurricular problem today is to preserve the close doctor-patient relationship and let the third party deal with the patient and not with the doctor.

Tony J. Trapasso, M.D.
Sault Ste. Marie

I have strongly felt there should be a closer, more intimate and fraternal tie between the private practicing profession and the *medical centers of the state.* Better communications always foster better medical care and knowledge for all parties concerned. The new eager young residents in our so-called ivory towers should have more than a passing impersonal correspondence acquaintanceship with the referring physician. Then such foolish mistakes as telling a patient that a specialist for check-ups is no closer than one hundred miles away when in reality one is present in his home town, would never occur.

Book Review

A Guide to Dermatohistopathology, by Hermann Pinkus, M.D., M.S., and Amir H. Mehregan, M.D., both of Detroit.

Doctor Pinkus is professor and chairman of the Department of Dermatology and Syphilology; associate, Department of Pathology, Wayne State University School of Medicine; senior attending dermatologist at Detroit General Hospital and chief, Dermatology Section, VA Hospital, Allen Park.

Doctor Mehregan is adjunct associate professor, Department of Dermatology and Syphilology, and associate, Department of Pathology, Wayne State University School of Medicine; senior associate dermatologist Detroit General Hospital.

Appleton-Century-Crofts, Educational Division, the Meredith Corporation, publishers of the book, report that the volume "provides a comprehensive guide to the diagnosis of histopathology of the skin." The book "reflects a modern, interdisciplinary approach to the problem. In addition, there are detailed sections on normal skin structure and technique, well illustrated by an outstanding collection of photomicrographs."

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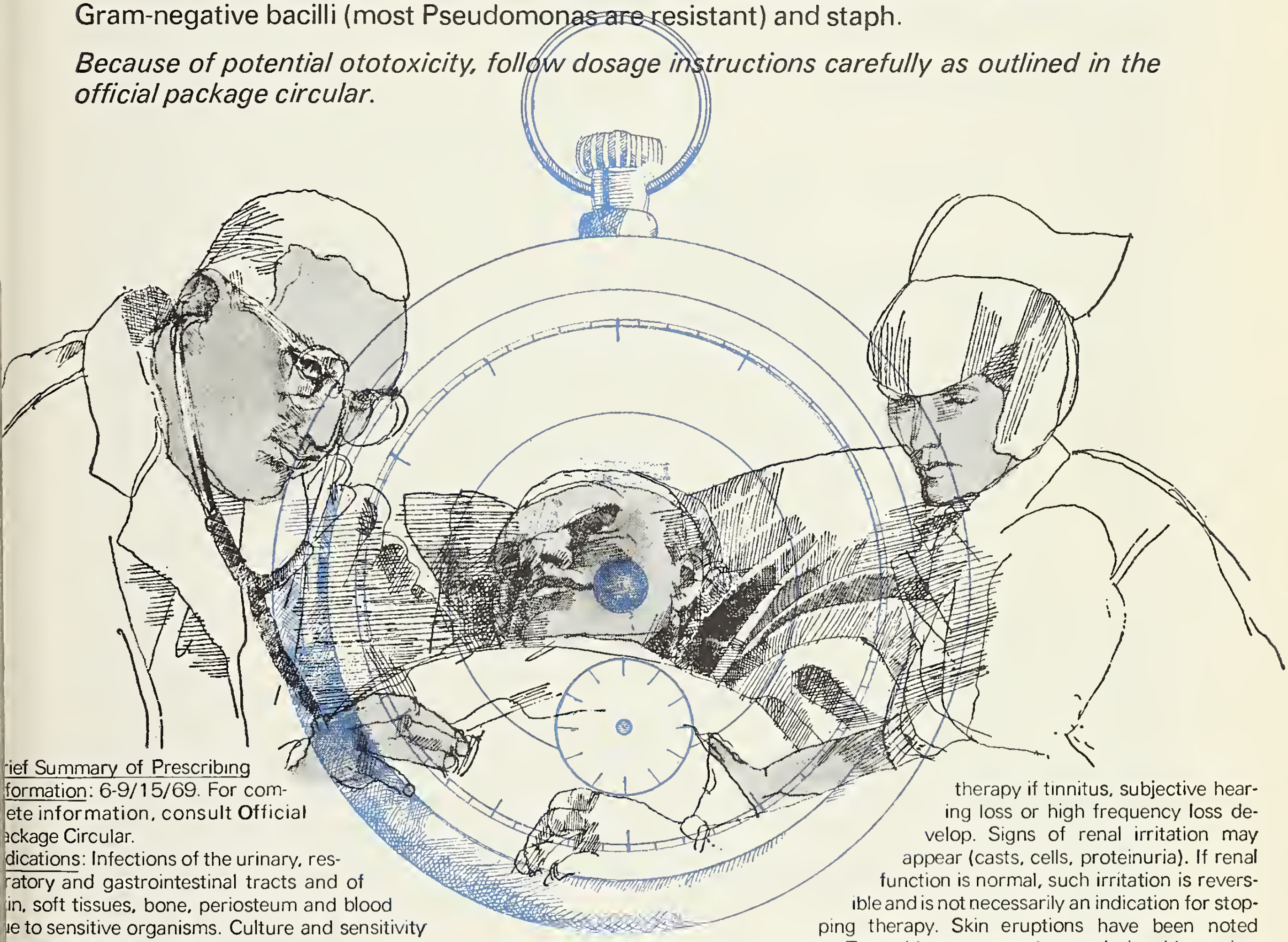

rief Summary of Prescribing formation: 6-9/15/69. For comete information, consult Official ackage Circular.
dications: Infections of the urinary, resratory and gastrointestinal tracts and of in, soft tissues, bone, periosteum and blood ie to sensitive organisms. Culture and sensitivity udies should be performed.
ontraindications: A history of hypersensitivity to the drug. ior auditory damage by kanamycin or other agents may be a contraincation if effective alternative therapy is available.
arnings: Since the drug is excreted almost entirely by glomerular ration, renal malfunction can cause abnormally high serum levels of namycin which may prove ototoxic. Assess renal function periodilly, both before and during therapy. Renal dysfunction or pre-renal otemia sharply increase the risk of ototoxicity and permanent deafss. In such cases decrease the size and frequency of doses. Discontinue namycin and check hearing if azotemia increases. In older patients d patients receiving a total dose in excess of 15 Grams, watch carely for signs of ototoxicity.
ecautions: If mycotic or bacterial superinfection occurs, discontinue namycin and initiate appropriate therapy. Cumulative ototoxic effects ay be produced by concurrent or consecutive use of other ototoxic ugs. High doses may cause irritation at injection sites. The drug *should t* be physically mixed with other antimicrobials.
lverse Reactions: Severe irreversible hearing loss may occur. Stop therapy if tinnitus, subjective hearing loss or high frequency loss develop. Signs of renal irritation may appear (casts, cells, proteinuria). If renal function is normal, such irritation is reversible and is not necessarily an indication for stopping therapy. Skin eruptions have been noted rarely. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in postoperative patients until recovery from anesthesia and muscle relaxants is complete.
Dosage and Administration: The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gram daily and should not exceed 1.5 Gram even in the heaviest patients. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours.
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The Risks In:

Intracranial Obliteration Of Berry Aneurysms

BY HARVEY GASS, M.D.
DETROIT

This is a retrospective analysis of the results of efforts at intracranial eradication of berry aneurysms of the brain in one hundred cases performed by a single surgeon in a single hospital. This constancy of experience provides a clear view of the surgical prognosis when intracranial clipping of an aneurysm is recommended.

The intracranial surgical treatment of aneurysms of the brain has been evolving for the last two decades. Recent publications in the field have increasingly been concerned with sophisticated techniques not generally available except in a few large medical centers. These include cardio-pulmonary bypass for controlled circulatory arrest and profound hypothermia, stereotaxic electrically induced thrombosis of aneurysms, occlusion of aneurysms by iron particles under magnetic control.[1,2,3,4]

Such efforts suggest that ordinary techniques that have developed and are in general use by neurosurgeons have gone as far as possible towards the surgical solution of this problem and lack perfection.

Several reports summarizing surgical results have been reviewed in the Cooperative Study of Intracranial Aneurysms and Subarachnoid Hemorrhages.[5] That study was based on the cumulative results of intracranial surgery on aneurysms from 20 large centers. What was added to our knowledge of surgical prognosis by sheer numbers of cases was offset by introducing increased variables when lumping together the experiences of different surgeons, different surgical philosophies, different degrees of aggressiveness, different techniques, etc; not to mention that these cases represent services performed at large neurosurgical centers where presumably service and technical advantages might be available.

Since the vast number of patients with this condition cannot reach centers with large neurosurgical services, not only for socio-economic reasons, but because they are not safely transportable or there is not enough time, and since the majority of practicing neurosurgeons are not part of such centers, the clarification of prognosis is particularly important to the practitioner in this country.

This report summarizes the results of intracranial surgery for aneurysms in one hundred consecutive cases, all performed by a single neurosurgeon in a single institution.* Constancy of experience may provide a relatively purer view of what to expect from the general neurosurgical practitioner today with this treatment. The major variables, aside from those inherent in the disease, have been the changes in technique, associated with innovations introduced during the years covered by this series (1954 to 1968) and the improvement in skill based on the surgeon's own increasing experience with these lesions.

The major technical innovations which were introduced over the years include:

1. Controlled induced hypotension until the aneurysm is clipped.
2. Hypothermia — (later abandoned).
3. Brain shrinking agents.
4. A variety of improved aneurysm clips.
5. Optical aids for magnification during surgery.

The surgical goal in these hundred cases has always been the obliteration of the aneurysm while sparing the parent artery with postoperative angiographic proof that this has been accomplished. In 98 cases eradication of the aneurysm was satisfactorily achieved although this entailed permanent occlusion of the parent artery also in seven cases (trapping). The remaining two aneurysms were treated by wrapping with muscle.

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*Sinai Hospital of Detroit

scientific papers

RESULTS IN 100 PATIENTS

Age	Total	Living	Dead	Normal	Minor Deficit	Major Deficit
0-9						
10-19	1	1		1		
20-29	7	5	2	4		1
30-39	20	17	3	13	2	2
40-49	38	29	9	23	2	4
50-59	21	12	9	8	1	3
60-69	13	8	5	5	2	1
Total	100	72	28	54	7	11

TABLE 1

In 66 of 72 surviving patients postoperative angiography was done and confirmed the operator's impression of aneurysmal eradication. None of the seven patients who had a "trapping" procedure done, ended up well, three expiring and four being left with major deficits. Two patients had postoperative subarachnoid hemorrhages. One of these occurred in a patient six weeks postoperatively, and four vessel angiography at that time failed to visualize an aneurysm. She recovered and has remained well since. A second patient had a subarachnoid hemorrhage six months following surgery due to a rupture of an undetected second aneurysm on the other side of the brain which was considered inoperable.

These 100 cases represent all the intracranial berry aneurysm surgery done at this hospital, and with only a few exceptions, include all the proven aneurysms appearing at that hospital referred for neurosurgical treatment. A number of them originated at other hospitals and were transferred for treatment.

Those who were considered inoperable were several patients who were moribund when seen, and a few arteriosclerotic fusiform aneurysmal dilatations of basilar or carotid artery. A single unruptured giant aneurysm, the size of a lemon and presenting as a slowly expanding tumor in the temporal lobe, is not included in this series, nor is another giant aneurysm which presented as a posterior fossa tumor. Only one posterior fossa aneurysm on the vertebral artery, was encountered.

ALTHOUGH BERRY ANEURYSMS of the vertebro-basilar system are rare, some others may have been missed, since in the early years of this series angiographic visualization of the vertebro-basilar system was not done routinely in cases of subarachnoid hemorrhage if both carotid angiograms were negative, nor if an aneurysm was demonstrated in the anterior circulation which clearly was the one that bled. Two cases of giant aneurysms of the carotid artery were not treated by intracranial surgery; one was not treated surgically at all, and the other had her internal carotid artery successfully ligated. This was the only instance where carotid ligation was resorted to at this hospital in the treatment of berry aneurysm during these years.

There are many different features of an aneurysm problem that may affect the outcome (anatomical relationship to afferent and efferent branches, detailed aneurysmal configuration, presence and degree of spasm, associated hematomas, collateral circulations, edema, electrolyte status, hypertension, etc.) but in a limited retrospective analysis such as this, only the most general ones are relevant in each case and justify consideration. These are: (1) age category, (2) location of aneurysm, (3) condition of patient at time of surgery and (4) time elapsed from last hemorrhage to surgery.

ANEURYSM LOCATION has been categorized into (a) those arising from the anterior cerebral artery system including the anterior communicating artery, (b) those arising from the middle cerebral artery system, (c) those arising from the intracranial intradural portion of the internal carotid artery including carotid-ophthalmic origin, (d) those arising from the internal carotid artery at the approximate junction with the posterior communicating artery (these have been singled out from others arising from the trunk of the internal carotid artery because of their frequency and unique identity, and are referred to as posterior communicating artery aneurysms) and (e) those arising from the vertebro-basilar arteries or their branches of which there is only a single example in this series. An occasional junctional origin at the bifurcation of the internal carotid artery into anterior and middle cerebral arteries was classified in the internal carotid category.

OF CRITICAL IMPORTANCE in determining the surgical outcome is the condition of the patient at the time of surgery. In this summary the Botterell[6] classification was used with patients graded into five categories based upon their immediate preoperative condition.

Grade 1 — conscious patient with or without signs of blood in subarachnoid space.

Grade 2 — drowsy patient without significant neurological deficit.

Grade 3 — drowsy patient with a neurological deficit and probably an intracerebral clot.

Grade 4 — patient with major neurological deficit and deteriorating because of large intracerebral clots, or older patients with less severe neurological deficit but pre-existing degenerative cerebrovascular disease.

ANALYSIS BY GRADE
(Condition of Patient at Time of Surgery)

Grade	Living	Dead	Normal	Minor Deficit	Major Deficit	Total
1	40	6	35	2	3	46
2	18	4	14	1	3	22
3	7	4	1	3	3	11
4	7	9	4	1	2	16
5	0	5				5
Total	72	28	54	7	11	100

TABLE 2

Grade 5 — moribund or near moribund patient with failing vital centers and extensor rigidity.

At the time this graduation system was introduced the importance of angiospasm in producing ischemic focal neurological deficits was not fully appreciated, so that those classified as Grade 3 or lower may often be in their state not as the result of hematoma, but of ischemia, and when this situation is judged to exist it has recently become our practice to delay or cancel surgery. Otherwise the effort has been made to operate on aneurysm patients who have hemorrhaged, as soon as possible after the recovery from the initial insult of the hemorrhage is under way, in order to obviate the possibility of succumbing to a recurrent hemorrhage.

In general, the ideal period has been between three to seven days after the hemorrhage or as soon as practicable when hemorrhage from an unruptured aneurysm seems imminent (e.g., retro-orbital pain and a third nerve palsy, usually indicative of an unruptured posterior communicating artery aneurysm). Despite this practice, not infrequently, an aneurysm will rebleed and the patient succumb during the period of investigation or preparation for surgery. This heart-rending experience continually presses the surgeon to avoid delays in the administration of surgical treatment.

RESULTS

No patients were classified as a mortality if they left the hospital alive, even if death ensued subsequently. Of the 72 surviving patients, two are known to have succumbed several months to a year later as a consequence of the initial subarachnoid hemorrhage and/or the surgery. A third late death was the result of a subarachnoid hemorrhage from an untreated aneurysm on the opposite side of the brain.

Patients listed as normal had no detectable neurological deficits. Those listed as having a minor deficit were those with minor neurological residuals such as an ocular palsy, minimal limb weakness or speech deficit or an occasional seizure, none of which were disabling to performance of their usual life-activities. Those listed as having a major deficit were those who were totally or seriously disabled by such things as a hemiplegia, a major degree of aphasia, or dementia. Two of the three late deaths previously referred to, occurred among patients who had been left with major deficits.

Reference to **Table 1** indicates that of our 100 patients, 28 died following surgery and 72 survived. Fifty-four of the survivors were normal, and seven had minor deficits, so that a total of 61 patients would be classified as a good result and cured of their aneurysms. Eleven patients were left with a major deficit, so that a total of 39 patients ended up with poor results.

Attention should be brought to the fact that of 34 patients over the age of 50 operated upon, 14 or almost 50% died, whereas only 14 of 66 patients under the age of 50 operated upon succumbed. Likewise, four of the 20 survivors over the age of 50 had major deficits whereas only seven of the 52 survivors under 50 were left with major deficits. It would appear, then, the outcome in the older age groups is less promising than in the younger age groups.

ANOTHER SIGNIFICANT OBSERVATION concerns the outcome related to the condition of the patient at the time of surgery, which is evident in **Table 2.** Here it is seen that of 68 patients operated upon in Grades 1 and 2 condition, there were 10 deaths and six major deficits, whereas in 32 patients operated upon in Grades 3, 4, and 5, there were 18 deaths and five major deficits. All the patients operated upon in Grade 5 condition expired. A number of the patients operated upon in Grades 3, 4, and 5 condition were done in the days before it was realized that ischemia secondary to spasm of the major arteries as the result of subarachnoid hemorrhage and/or edema might be responsible for their state, and that delay in surgery until these conditions improved, if they would, would have been desirable as suggested by Hunt and Hess.[7] This knowledge, today, would improve the statistical picture in Grades 3, 4 and 5 patients, inasmuch as a delay in surgery would have allowed some of these patients to advance to Grade 1 or 2 condition and others who were destined to expire as a consequence of untreatable spasm would not have been charged against the surgeon.

It is our practice, now, to operate upon patients in Grade 3 and 4 only when their condition is believed to be unequivocally associated with an expanding hematoma.

Reference to **Table 3** gives some indication as to the expected outcome dependent upon the location of the aneurysm. The best results occurred in the group of posterior communicating

ANALYSIS BY LOCATION

(Anterior Cerebral Includes Anterior Communicating Aneurysms)

Location	Living	Dead	Normal	Minor Deficit	Major Deficit	Total
Ant.Cerebral	16	11*	12[A,B]	2	2	27*
Mid.Cerebral	11	10*	9	0	2	21*
Int.Carotid	16	5	10[A,C]	1	5[D]	21
Post.Comm.	28	3	22[E,F]	4[G]	2[D]	31
Vertebral	1	0	1	0	0	1

TABLE 3

* One patient had both anterior and middle cerebral aneurysms clipped at one operation.

A Packed with muscle only. Living and well two years later.

B Postoperative subarachnoid hemorrhage; four-vessel angiography negative.

C Unruptured, unoperated aneurysm of internal carotid on other side.

D Late death.

E Required Holter valve subsequently.

F Another aneurysm on opposite side was previously successfully clipped elsewhere.

G Ultimately died from effects of another inoperable aneurysmal hemorrhage on opposite side.

aneurysms. Twenty-eight of 31 of these patients survived the operation, 22 being normal and four having minor deficits. In other words, 26 of these 31 patients ended up with good results. Three were surgical deaths, and two ended up with a major deficit, one of whom represented a late death.

The number of good results are about the same in the other three large categories, namely; 10 normal and one minor deficit from among 21 internal carotid aneurysms with 5 deaths and 5 major deficits in that group; 9 normal from among 21 middle cerebral aneurysms with 10 deaths and two major deficits; 12 normal and two minor deficits from among 27 anterior cerebral aneurysms with 11 deaths and two major deficits in that group. One of the patients who died had both an anterior cerebral and middle cerebral aneurysm treated at the time of operation.

THIS EVALUATION includes a number of patients who by virtue of their poor preoperative state or age were not promising candidates for any type of treatment. If the breakdown into aneurysm location includes elimination of Grades 3, 4 and 5 patients, the outlook is considerably more favorable, as indicated in **Table 4**. Here, it is seen that amongst patients listed as Grade 1 and 2 in the anterior cerebral group there were three deaths and one major deficit among a group of 10 patients. In the internal carotid group there were three deaths and three major deficits among a group of 16 patients; and among a group of 25 posterior communicating patients there were two deaths and two major deficits resulting.

The clouding of the prognosis that the poor preoperative state makes in all categories of aneurysms by location is obvious. Nevertheless, the surgeon cannot refrain from tackling all Grades 3, 4 and 5 patients despite their poor prognosis, since a number of these may be harboring intracranial hematomas, either intracerebral or subdural, which, if untreated, may contribute to the progressive deterioration of the patient. In the 100 patients, 26 were noted to have significant surgical intracerebral hematomas the size of a walnut or larger, and six had significant subdural hematomas.

Surgery was performed on the first day following the subarachnoid hemorrhage in eight patients, seven of whom were categorized as Grade 4 or 5. Of these, 3 survived (two Grade 4's and one Grade 2) and 5 expired (three Grade 4's and two Grade 5's). Forty-one of the 100 patients were operated upon between eight and 14 days, 10 between 15 and 21 days, six between three and six weeks, and two over six weeks after the last hemorrhage. Eleven patients had aneurysms which had never ruptured.

An effort was made to analyze these results from a point of view of the influence of the surgeon's experience on the outcome. Although this report does not cover the author's total experience with this type of surgery, covering a span of 14 years as it does, the cases done towards the end of the period, reflect skill and knowledge accumulated from experience in this relatively new field. The first 35 patients operated upon

ANALYSIS BY LOCATION AND GRADE

(A single grade I vertebral aneurysm who ended up normal is omitted)

Grade	Anterior Cerebral (Includes anterior communicat.)					Middle Cerebral					Internal Carotid					Posterior Communicating				
	Living	Dead	Normal	Minor Deficit	Major Deficit	Living	Dead	Normal	Minor Deficit	Major Deficit	Living	Dead	Normal	Minor Deficit	Major Deficit	Living	Dead	Normal	Minor Deficit	Major Deficit
1	8	1	6	1	1	6	2	6	0	0	8	2	7	0	1	18	1	16	1	1
2	5	2	5	0	0	2	0	2	0	0	5	1	3	0	2	5	1	3	1	1
3	0	2*	0	0	0	1	2*	0	0	1	3	1	0	1	2	3	0	1	2	0
4	3	5	1	1	1	2	3	1	0	1	0	1	0	0	0	2	0	2	0	0
5	0	1	0	0	0	0	3	0	0	0	0	0	0	0	0	0	1	0	0	0
Total	16	11*	12	2	2	11	10*	9	0	2	16	5	10	1	5	28	3	22	4	2

TABLE 4

* One patient had both anterior and middle cerebral aneurysms clipped at one operation.

EFFECT OF SURGEON'S EXPERIENCE ON OUTCOME

	First 35 Patients					Lost 35 Patients				
	Living	Dead	Normal	Minor Deficit	Major Deficit	Living	Dead	Normal	Minor Deficit	Major Deficit
Number	24	11	20	1	3	28	7	20	4	4
Per cent	69	31	57	3	9	80	20	57	12	12

TABLE 5

were compared with the last 35 patients operated upon as seen in **Table 5.** It is to be noted that the surgical mortality dropped from 31% to 20% with the percentage of satisfactory results in the first 35 totalling 60%, and the percentage of satisfactory results in the last 35 totalling 69%. This improvement may reflect not only the surgeon's experience, but the improvement based upon innovations in technique that were available in the last 35 that may not have been available in the first 35.

THE DECISION FOR COMMITMENT to intracranial surgery for eradication of a berry aneurysm is a grave one. Among patients who are already in poor condition from rupture, many will fare badly whether operated upon or not. There is nothing to be gained, it seems, by subjecting to intracranial surgery moribund or near-moribund patients, nor those in whom spasm, detectable in the angiogram, is recognized, until their condition improves. The decision to operate upon the remaining is based upon the hope that a recurrent hemorrhage will be prevented and any devastating hematomas will be removed without fatality or major disability resulting. There were 27 Grade 3 and 4 patients operated upon and nine ended up normal or with a small deficit (some of the early 27 were unwittingly operated upon during the phase of spasm). Therefore, upwards of 33% of this remaining group of poor condition patients may be expected to have good results.

The expectancy in relatively good condition patients has already been defined. This must be considered in light of the patient's age and the location of the aneurysm. The prognosis in this group is far more promising and acceptable. Notwithstanding the experience of the surgeon, which may well add a significant factor to the outcome, there is still a minimum expected residue of undesirable results which at this point in time is probably irreducible. Whether the sophisticated techniques currently being explored can change this remains to be seen, but in view of the impracticality of making such techniques available where and when needed, it is doubtful that even if they prove advantageous, they will alter the overall picture in the future.

THE AREAS where further improvement may yet occur that will affect traditional surgical technique include, especially, methods for the control of angiospasm, greater facility in microsurgical technique, and possibly still further refinement in clips and clip applicators. The benefit of the pioneering experience of Drake[8] and others in the management of aneurysms of the posterior circulation has not yet been realized by most neurosurgeons. Finally, the technique of aneurysm coating with various plastics which this paper, that is concerned primarily with eradication of aneurysms, does not deal, will undoubtedly find further application and development in the intracranial treatment of aneurysms.

SUMMARY

The results of intracranial surgery for the eradication of berry aneurysms of the brain in 100 patients have been presented. An analysis of these have been made from the point of view of several major variables: age of patient, location of aneurysm, condition of patient at time of surgery, and the surgeon's experience. In addition data regarding time of surgery with respect to last hemorrhage and incidence of hematomas was presented.

It is hoped that the constancy of this experience will enable the physician who must face the prospect of such surgery for his patients, to get a clearer picture of the prognosis.

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Drug And Therapy Problems

Interested Michigan physicians are invited to direct any questions they might have on drugs and their use to the authors of this column, which appears occasionally in **Michigan Medicine.** *Requests for information should be mailed to Robert E. Pearson,, M.S., and Fred J. Salter, Pharm.D., Michigan Regional Drug Information Center, Hospital Pharmacy, University Hospital, Ann Arbor 48104. All questions will be answered and will appear in this column as space permits. The column appears courtesy of the Michigan Association for Regional Medical Programs.*

BY ROBERT E. PEARSON, M.S.
FRED J. SALTER, PHARM. D.
ANN ARBOR

Q. Where may I obtain a skin test for echinococcus?

A. At the present time there is no commercial source for echinococcus skin test. The Bureau of Laboratories, Michigan Department of Public Health will accept whole blood or serum for testing. The sample should be accompanied by a MDPH F22 Misc. Form. The MDPH will forward the sample to the National Communicable Disease Center where a hemagglutination and a flocculation test will be done. A history of the patient is not required.

Q. What is the dose of amitriptyline for enuresis?

A. Although the use of amitriptyline for enuresis is not officially approved by the FDA, current researchers are using 10 mg. for children under 6 yrs. of age and up to 25 mg. for older children. The dose is given at bedtime.

Q. What is the fatal dose of Librium®?

A. The manufacturer has informed us that they have not received any case reports of a fatality due to Librium®. They have a case report of a patient who ingested 25,000 mg. and survived.

Q. What is the mechanism of action of the investigational drug lactulose used for portal-systemic encephalopathy?

A. Lactulose is a synthetic disaccharide and as such is not hydrolyzed in the small intestine. The lactulose passes into the colon where it is split into lactic acid and other normally occurring organic acids. The resultant lowering of pH changes the colonic flora yielding a decrease in proteolytic bacteria. The decrease in proteolytic bacteria decreases the nitrogenous wastes, which are "toxic" in portal-systemic encephalopathy. The diarrhea which ensues due to the acid-induced increase in motility and increased fermentative processes removes those nitrogenous wastes which do accumulate. References are available on request.

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Although the conclusions pertaining to the particular case cannot be proven conclusively (negative DDA test) the article points out the necessity for awareness of the problem. With the insecticide months well upon us, we must all be aware of the problems of insecticides, not just DDT, but malathions and others.

A Case Of Human Pesticide Poisoning

BY W. A. GILPIN, M.D.
DETROIT

In 1959 following an aerial spray program in Northwest Detroit by the Michigan State Agricultural Department for Japanese beetle infestations, an awareness of pesticide poisoning became evident. Four patients with mild toxicity consisting of respiratory symptoms were seen. They ranged in age from 12 to 50. Medical literature was sparse on this subject so correspondence with Rachel Carson, Ph.D., the author of "Silent Spring," was initiated. The four cases were recorded in her book and an awareness of a new medical problem ensued.

Since World War II, the chemical industry has produced ever increasing quantities of pesticides in great varieties and strength. It is the so-called hydrocarbons (DDT, Aldrin, Dieldrin, Entrin, Chlordane, Lindane, Heptachlor, Toxaphene) that have become harmful to wild life as well as humans. D.D.T., the commonest and the most widespread, is the hydrocarbon this article will pursue.

United States chemical companies began to produce DDT in high volumes in the 1940's.

1948-1949	38,000,000 lbs.
1951-1956	110,000,000 lbs.
1956-1961	152,000,000 lbs.
1961-1966	150,000,000 lbs.
1967	103,000,000 lbs.

There is now a downtrend in their production. It has been estimated that 46,000,000 lbs. of pesticides are used annually in the United States covering 90 million acres, with one acre out of 10 revealing DDT in the soil. This is a $20 million per year business for the chemical industry.

DDT HAS thoroughly permeated our environment. It has been by far the most widely used pesticide and is toxic to a broad spectrum of animals including man. It is found in water, the air, soil and even in the gulls in the Antarctic. It is found in adipose tissue of man world-wide. Evidence portrays that it is spread by wind and water much as radioactive fall-out. Migrating fish and birds transport it thousands of miles.

DDT has a low solubility in water, (upper limit one part per billion) but as algae and other organisms in the water absorb the substance in fats, it becomes highly soluble. DDT is extremely stable in the environment with a slow breakdown. DDT has a long-life in trees and soil in the range of tens of years.

Ecologists have become aware that pesticide residuals have now accumulated to levels that are catastrophic for certain animal populations, particularly carnivorous birds. The pesticides also destroy predators and competitors that normally tend to limit proliferation of the pest. Pests tend to develop new strains that are resistant to DDT Our chemical onslaught is resulting in the extinction of certain species of wild life, notably carnivorous and scavenging birds, e.g., Hawks, Eagles, and Osprey. Destruction of species balance, reproduction, and behavioral alterations in wild life have been proven. Added pollution to the environment is a fact.

Federal seizure of ten tons of Coho salmon in February 1969, from Lake Michigan verified the fact that DDT levels were over presumed safe limits. The United States Bureau of Commercial Fisheries warned that DDT levels would interfere with reproduction of lake trout, salmon, and other species. As a result, the Michigan Department of Agriculture banned the use of DDT in April 1969; but, chemical DDT could be sold and used in Michigan if in transit from the manufacturer by June 27, 1969.

New research into tolerance levels in humans

The author is an internist and representative of MSMS to the Michigan Pesticide Advisory Committee. He is a member of the attending staff at Mt. Carmel-Mercy Hospital in Detroit.

will be studied. The effect of killing non-target organisms, accumulation in the food chains, lowered reproductive potential, resistance to DDT sprays, synergistic effects, chemical migration, accumulation in the ecosystem, and delayed responses are to be studied.

CONSERVATION GROUPS and many scientific groups are well aware that DDT affects wild life, and will eventually cause side effects in humans. It is estimated that four lbs. of pesticides are used for every man, woman, and child in America each year. It becomes an enormous potential problem from a health point of view.

At a Michigan State Medical Society meeting in the fall of 1965, Herman Kravill, Chief of the Pesticide Control Committee for the United States Department of Health, indicated that there were 60,000 pesticides on the market. Over 100 of these were toxic. Twenty percent of all pesticides were used in the state of California. Of all the pesticides used in the United States at that time, the majority were largely hydrocarbons, or organic phosphorous compounds. He went on to establish the fact that DDT was found in 80 parts per million in trout. As a result, many died and thousands developed cancer-like tumors.

He went on to say that pesticides were appearing in our meats, seafoods, eggs, milk, fruits and vegetables. Thirteen p.p.m. of DDT were found in human milk, whereas cow's milk had three quarters less DDT. In humans country-wide at that time, there were 16.52 p.p.m. of DDT in adipose tissue, 1.44 p.p.m. in the liver, 1.5 p.p.m. in the kidney, 1.50 p.p.m. in the brain, .45 p.p.m. in the gonads. This established the fact that humans did carry DDT.

A reproductive failure in certain birds was shown then, and has been proven since in Pheasants, Mallards, Eagles, Osprey and Hawks. The effects of DDT have no antidote and it is now thought the average level of DDT in humans, in p.p.m., is 12.90 percent largely derived from food. It is now known that DDT is passed through the placenta to the fetus.

LABORATORY EXPERIMENTS with animals indicates DDT attacks the central nervous system, upsets body chemistry, distorts cells, accelerates gene mutation, reduces drug effectiveness and affects calcium absorption by the bones. Recent Hungarian experiments with mice emphasized DDT's carcinogenic possibilities and they have banned its use. Carcinogenic properties were confirmed by the National Cancer Institute's interim report on the long-term toxic effects of 130 chemical compounds. Specifically it tagged 11 common pesticides (including DDT) and cast strong suspicion on 19 other chemicals as sources of tumors in mice. It also stated that it is reasonable to conclude, the great mapority of the DDT-induced tumors have malignant potentiality.

Kenneth P. Du Boss, professor of pharmacology in the Pritzker School of Medicine of the University of Chicago discovered that insecticides including DDT can stimulate the liver to produce abnormally high levels of certain enzymes that cause increased detoxification of drugs that may render the drug therapeutically ineffective at normal dosage levels. Tests in the toxicity laboratory conclusively demonstrated that frequently used sedatives as barbiturates are counter-acted by DDT.

It is of interest to note that 70 workers exposed to DDT for ten years in a Soviet Study did show increased acid pepsin secretion in the stomach; in the liver there was pronounced disturbance of protein and sugar metabolism with pigmentation, detoxication and secretion functions. The United States Department of Public Health Study recently noted that fairly high doses of DDT in the diets of rats formed liver malfunctions, but monkeys in a similar study revealed no ill effects.

It has been demonstrated that DDT can cause adaptation of enzyme systems although the general biological significance is unknown. DDT in rats, it is noted, is an "enzyme inducer," and not only breaks down drugs but a number of different substrates, including estrogen. In birds, estrogen mediates calcium metabolism causing the birds to accumulate calcium in the hollow parts of the skeleton for later transfer by way of the blood stream to the oviduct, where the egg shell is formed. Thus, it was hypothesized that by breakdown of estrogen and upsetting calcium physiology, DDT was responsible for avian reproduction failures.

Also in the past few years it has been discovered that the DDT induces certain enzymes in the liver that decompose steroid sex hormones creating a hormone imbalance. DDT levels in the human environment caused a similar breakdown in several laboratory animals, including rats, whose sex hormones, estradiol and testosterone, are thought to be identical to those of man. Human cells (Chang liver and He La cells) have been exposed in cell culture to DDT. DDT proved toxic in the cells, and induced progressive morphological changes leading to cell destruction (Gablips and Friedman, Massachusetts Institute of Technology).

DDT has been used as a wettable powder of 25% to 75%, an emulsifiable concentrate of 50% or less, in aerosol bombs, and as a dusting agent in various concentrations. Emulsions and wettable powder suspensions of five percent have been commonly used in spray operations. Dusting applications have contained 10 percent of DDT and many household insecticide sprays have contained five percent solution of DDT in purified kerosene. Absorption is through the alveoli and intestinal tract and through the skin as a solution of fats and oils.

DDT CAUSING illness in man is unknown. Cases of DDT 648 p.p.m. in adipose tissue of five years in man have caused no injury. However, the tolerance is extremely variable from person to person. Symptoms usually begin in 30 minutes to 3 hours with malaise, headaches, fatigue, parathesias of the tongue, lip and face. With large exposures, parathesias of the extremities, extreme apprehension, disturbances of equilibrium, dizziness and confusion with tremor, and convulsions develop in serious cases. Pupils become dilated and there is increased sensitivity to touch and pain in areas of parathesias. Loss of vibration sensation can occur in the fingers and toes. Coordination tests may show poor results. Mild cases develop increased pulse rates while more severe exposures result in slow irregular pulses. Transient jaundice has been reported rarely.

Laboratory findings are usually negative. Urinalysis for DDA (a metabolite of DDT) are positive where concentrations of DDT have been severe. Blood for analysis may be helpful but only the United States Public Health Toxicology Laboratory in Atlanta, Georgia is equipped to run these tests. Cholinesterase levels before DDT exposure and after may be helpful. Thus laboratory tests in humans are available but highly specialized to determine results.

In 1963, with a naturalist, Dr. Walter Nickell from the Cranbrook Institute of Science, we began warning the Forestry Department of the City of Detroit, of the hazards of using DDT continually in the spray programs for Dutch Elm Disease. This operation had progressed since 1957 twice yearly involving 400,000 Elm trees, using a 25% emulsion of DDT in water forced out with spray mist machines. Several meetings with the City Council and the Forestry Department resulted in little progress until last year when a sanitation program (cutting all diseased trees) and a chemical substitute, Methoxichlor, began to be used. Breakdown of this latter chemical was far more rapid. Sanitation alone is still being refused by the city even though this is the best treatment in the long run from a total ecological system approach.

A Mrs. J. A., a 56-year-old school teacher, on April 12, 1962 came in direct contact with DDT sprayed by the City of Detroit for Dutch Elm Disease. The wind blew the DDT emulsion over the front of her house and surrounding shrubs, covering her windows as well. While immediately trying to clean the DDT off her windows she had her right hand pricked multiple times by brushing by a Phitzer bush while moving the step ladder.

She washed windows for one hour and then developed dizziness, ringing in her ears, and began "shaking all over." A cough developed along with "blood shot" eyes with burning. She became nauseated and three hours later developed numbness on the right side of her face, right arm, back and abdominal area with marked twitchings in the areas. Her fingers tingled and she developed small blisters at her finger tips with marked swelling of her right hand, double the normal size. She became extremely stimulated and apprehensive and had a sleepless night.

THESE SYMPTOMS continued for several days accompanied by partial paralysis of her hand with inability to button her clothes, iron, wring out wash or open doors. Marked fatigue developed and despite Epsom Salt soaks her hand continued to remain severely "numb and swollen."

In May 1962 she consulted her family physician who prescribed tetracyclines and cortisone with improvement of edema in one week. Her other symptoms continued. She then consulted a dermatologist at Henry Ford Hospital who noted a slight residual swelling of her hand and a faint erythema. She appeared very nervous. No other signs were noted. CBC was normal except for a normacytic anemia. Urinalysis was negative, and VDRL was negative. Antihistamines with mild sedation were prescribed. The dermatologist felt she had a lymphedema associated with a contactant to be found in a menopausal nervous individual. Although her pulse was normal, her blood pressure had increased in nine days from 130/85 to 140/100. He then added Theelin. Little change occurred in her hand except she felt the Theelin had helped her anxiety state. She was referred to the Arthritic Clinic but did not return.

After she read a newspaper article about DDT toxicity, she was referred by Cranbrook Institute of Science and was seen on February 21, 1963 for the first time. Her subjective complaints were extreme nervousness, fatigue, twitching of the right facial area, right eye, right hand, right arm, and intermittent twitching of her back and abdominal muscles. Her hand, she complained, was partially paralyzed, sore, stiff, swollen each morning, and she was unable to close it. Her grip was poor. She still had occasional dizzy spells, headaches and cramps in her legs at night.

EXAMINATION REVEALED a fairly well developed, well nourished middle aged white female in no acute distress, but extremely nervous. Blood pressure was 150/102. Positive findings revealed slight stiffness of the fingers of her right hand and slight tenderness of the entire right hand to palpation. Her grip was 50% less than in her left hand. The entire function of her right hand was 30% of normal. Neurological examination was negative except for generalized hyperactive reflexes with marked hyperactivity of the right upper extremity. There was some loss of muscle tone. Sensation to touch and temperature changes were normal. Coordination of the finger to nose test was only 50%

of normal. Temperature, pulse, and respirations were normal. Petite muscular twitching of her right facial, right eyelids and right arm musculature was noted.

The rest of the complete examination was negative except for a slight anemia 3,300,000 red blood cells with a hemoglobin of 11.5 grams. White blood count was normal as was urinalysis. BSP was borderline. Cephalin Flocculation was 3+. Chest X-Ray and ECG was normal. Urine was sent to the Communicable Disease Center Laboratory in Atlanta, Georgia, for DDT and returned April 25, 1963 revealing a negative DDA (DDT metabolite) result. This was a microcoulometric gas chromatography test using a gaseous colormeter process.

Impression at this time despite DDA test was that she had DDT poisoning resulting in:

1. 30% paralysis and decreased muscle tone of right hand
2. Residual Central Nervous System damage with hyperactive reflexes probably from DDT poisoning
3. Mild Secondary Anemia
4. Subclinical Liver Damage (hepatic) on basis of borderline liver function

From two other cases I felt these impressions were accurate. Therapy consisted of moderate sedation, iron, and B complex in large doses over a period of four months and resulted in an improvement of 50% of the paralysis of her right hand, 25% of her motor coordination, but residual CNS damage still revealed hyperactive reflexes, anxiety and stimulation. Liver function reverted to almost normal findings. Her cephalin flocculation was 1+ with a normal BSP. However, her blood pressure remained 150/100. Her anemia improved to 3,600,000 and hemoglobin 11.8 grams. I felt these present residuals would remain. This case was tried in Detroit in June 1968 and won after a week of testimony by the chemical company involved with the City of Detroit and the Plaintiff. An appeal by the City and by the chemical company in the State Appeals Court was dismissed.

THIS CASE illustrates what can happen with the continued use of DDT without its ban. Even though DDT and chemically related insecticides have made enormous contributions to public health and agriculture, it is building up resistant insect populations in many areas and upsetting ecosystems. Substitute compounds can be used. DDT should be extinct.

Interior Secretary Walter Hickel has announced that the Federal Water Pollution Control Administration awarded a contract to the Aerojet-General Corporation to develop a self-destruct catalyst for DDT. The Secretary hopes to prevent future deposits of DDT from endangering the environment and to degrade the toxicity of pesticides already in the soil being used for human consumption.

A bill to prohibit the manufacturing or sale of DDT throughout the nation is now in Congress. With environmental pollution we must be protected or man will destroy himself. We as physicians must become aware of pesticide toxicity in man and attempt to support research that is constantly widening our knowledge into recognition of its human effect.

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Initial Experiences with Fathers In the Delivery Room

BY CHARLES W. ALDRIDGE, JR., M.D.
GRAND RAPIDS

Obstetricians can be proud of their accomplishments which have resulted in a decrease in both maternal and fetal mortality and morbidity. There can be no doubt that the moving of delivery from the home to the hospital was responsible for an increase in the safety of our patients.

However, hospital deliveries generally have become associated with greater anxiety and emotional trauma. One of the reasons for this has been that husbands, who were of great comfort and assistance to their wives at home, were separated from them in the hospital.

As interns and residents on the obstetrical service, most of us learned to deliver babies in hospitals which barred fathers from the delivery room, and often the labor room as well. For this reason, when we moved to private practice, we felt uncomfortable when the father was present. So, we have protected ourselves behind such statements as "It's against hospital policy" or "It's not allowed by the Health Department." The author's favorite excuse was the honest belief that he couldn't do his best for the mother, if the father was there "looking over his shoulder."

However, he began to have serious doubts about this as a result of experiences in delivering physician's wives. Occasionally, when one of his colleagues chose to stay with his wife in the delivery room, he found that he could function quite satisfactorily, even with a fellow physician "looking over his shoulder."

Also, reports coming from other hospitals and obstetricians scattered around the country recently have been noted indicating changing attitudes regarding the need to keep fathers out of the delivery room.

With this background, in 1968, it was decided to initiate a trial program of allowing fathers in the delivery room at St. Marys Hospital. All attending physicians with obstetrical privileges were notified that fathers were now allowed in the delivery room. The decision to do so would have to be made by mutual consent between physician, patient, and husband. It was also recommended, but not required, that both prospective parents prepare themselves by attending prenatal classes offered at any of the hospitals in the city of Grand Rapids.

The following routine has been established: The father is allowed to be present and stay with his wife in the labor room as previously. The nurses are instructed to explain to him what is happening and he is encouraged to support his wife in every way possible. When the patient is ready to be moved to the delivery room, he is given cap, gown, and mask. The father is not brought into the delivery room usually until after the mother has been prepared and draped; and often after a pericervical block has been administered. He sits on the stool at the head of the table which is usually occupied by the anaesthetist. He is given some simple instructions regarding watching in the mirror and how he might communicate with his wife by word or touch without contaminating the field. It is important to explain to him that he may excuse himself any time he wishes.

Verbal support to both father and mother is an important part of the delivery room atmosphere maintained by both doctors and nurses. Immediately after birth the baby is shown to both parents. Then, before the episiotomy repair, the father is asked if he would like to leave, "— to make a phone call" or "— to fill out the questionnaire." At this point, the need for him to stay with his wife has passed and he is usually perfectly willing to go.

STATISTICAL REPORT

We decided to evaluate this program by having questionnaires filled out by the mothers, fathers, and physicians. The delivery room nurses were also interviewed regarding their impressions of the program.

For one year, beginning June 1, 1968, a total of 150 couples participated. This was approximately nine percent of the total deliveries. At the present time, participation has leveled off at about 15 percent of all deliveries. Because information

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The author, a private practitioner, presented this paper at a meeting of the Michigan Society of Obstetricians and Gynecologists at Grand Rapids late in 1969.

was incomplete on some questionnaires, results were analyzed from that obtained from 141 cases.

Figure 1

Age	
Youngest	17
Oldest	39
Average	28

Parity	
0	14
1	39
2	27
3	15
4	15
5	7
6	8
7	4
8	4

There was wide variation in age and parity. The typical patient was a young gravida one or gravida two. Regardless of age or parity, it was evident that the majority of couples had equally satisfying experiences.

Figure 2 Attendance: Prenatal Classes

Mothers		Fathers
43	St. Marys	34
19	Blodgett	13
11	Butterworth	10
1	Other	9
58	None	53

Grand Rapids has an Inter-Hospital Childbirth Education Group which maintains good correlation between the classes at each hospital. Not enough parents attend these classes. We feel that these classes are extremely important for them, if they are to adequately understand the delivery room process and receive the maximum benefits from witnessing the birth of their baby.

Figure 3 Mother's Questionnaire

	Harder	Easier	Same
Labor	21	28	33
Delivery	27	44	31

Although most mothers reported labor and delivery to be easier or the same as expected, more of them reported harder labors and deliveries than we had anticipated. However, in spite of the harder delivery, this group all approved of the program and expressed the desire to participate again in their next pregnancy.

Figure 4 Mother's Questionnaire

Would you want your husband to be in the delivery room with you again?

Yes	140
No	1

Why?

Helps mother	64
Helps father	28
To share experience	34

Only one mother stated that she would not want her husband to be in the delivery room again. This patient was a 36 year old, gravida 8, registered nurse, who stated that she felt that her husband was too frightened that something might go wrong and that for his sake, she would not want him to have to go through it again.

The reasons why the mothers wanted their husbands in the delivery room with them, could generally be classified in three groups. First, the father's presence helped them (the mother). Second, the experience was good for the father. Third, sharing the experience was good for both of them.

Most of the mothers thought that they themselves benefited most from the experience. However, there were a few wives who stated, rather negatively, that they wanted their husbands to really see the suffering that they had to go through. Nevertheless, most of them felt that pleasing their husband or sharing with them was the main reason that they liked their husbands to be with them in the delivery room.

Figure 5 Whose Idea?

Mother's Questionnaire		Father's Questionnaire
11	WIFE	38
17	HUSBAND	31
92	Both	49
—	Doctor	4

Wives more often thought that the idea originated with both of them. Husbands more often thought that one or the other of them initiated the idea. In four cases, fathers indicated that the doctor initiated the idea.

Physician's Questionnaire

We obtained no adverse comments on the physician's questionnaires. The attitude of most of the attending staff whose patients participated varied from neutral acceptance to mild enthusiasm.

Discussion

The overall impression of this program has been favorable. By far, the most enthusiastic group has been the patients. However, this enthusiasm has not failed to impress the hospital personnel and physicians who have observed it. These parents are stable emotionally and are well-adjusted in their marriages.

We feel that many mothers benefit from witnessing and participating in the delivery of their baby; and that some husbands may also realize these benefits as well as be of assistance to their wives. Also, we believe that interfamily relationships begun in the delivery room, in this setting, will have good effects on the future emotional development of all of the three individuals involved.

There has been favorable acceptance of this program by all others concerned. In the newborn nursery, there has not been an increase in infection rates. There have not been any maternal complications nor has the care of the mother in the delivery room been compromised in any way because of the father diverting the attention of the nurses and doctors.

Failures

Certain situations have occurred when the father, who planned to attend, was excluded:

1. One patient had a rapid, almost precipitous delivery and there wasn't time to get the father into the delivery room.
2. Another patient underwent an induction of labor which progressed faster than expected. The father left the hospital and did not return before the delivery.
3. Two husbands were asked to exclude themselves by the obstetrician because there had been a prolonged hard labor and a difficult forceps delivery was anticipated. (On other occasions fathers were in the delivery room during breech births and low forceps delivery).
4. One father was excluded because the physician taking the regular doctor's calls did not feel that he should be admitted.

In two instances, fathers had to excuse *themselves* from the delivery room.

1. One became faint and had to leave. He felt that the fact that he had not eaten for fourteen hours had something to do with his condition.
2. Another had to excuse himself because of nausea and vomiting.

All other fathers presented absolutely no problems to themselves, their wives, or the delivery room personnel.

Contraindications

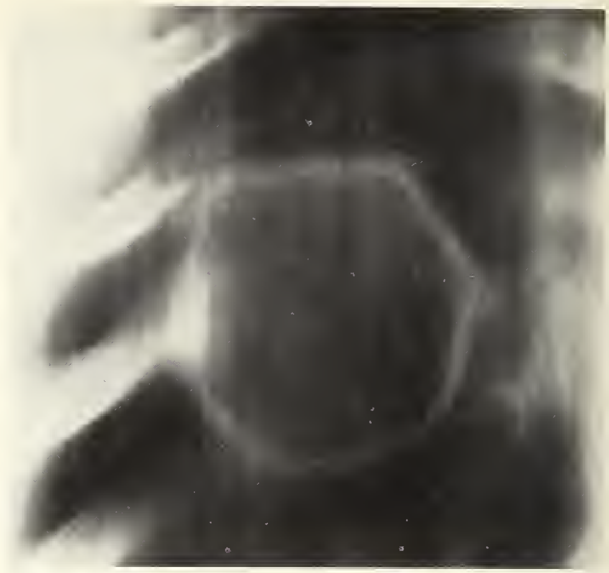
Because of the initial experiences, we have come to recognize certain relative contraindications. First, general analgesia or anesthesia. Second, rapid unorganized delivery. Third, if obstetrical complications, prolonged labor, or difficult forceps delivery is expected. Fourth, if both parents have not had prenatal instruction. We have the distinct impression that if, during labor, the husband is asked if he wishes to attend the delivery, and there has been no preparation for this, he may often feel that he is letting his wife down if he says "no" even though he is really not anxious to be in the delivery. room.

Summary

Fathers may attend their wives in the delivery room under selected circumstances without serious complications and often with remarkable psychological benefit to themselves and the family unit.

Such a program is not suitable for all or even most parents and physicians. Yet there are no valid reasons why similar programs could not be instituted by most hospital obstetrical services.

The Viewbox



BY RAYMOND S. KURTZMAN, M.D.
ASSOCIATE SCIENTIFIC EDITOR

DIAGNOSIS:

CYSTIC CARCINOMA OF THE LUNG

X-RAY FINDINGS:

On this body section roentgenogram of the right lung, there is a large relatively thin-walled cyst, with several irregular and bumpy areas on its inner surface.

DISCUSSION:

Cystic carcinomas of the lung are almost invariably squamous in type. They originate as cysts and grow that way, unlike carcinomas which become necrotic and excavate. The latter type generally has a relatively thick wall. Some metastases can grow as cysts. These also are squamous in type, originating from esophagus, bladder, or urethra. The differential diagnosis includes bullous disease, in which the walls of the cyst tend to be smoother, and various infectious cavities, in which the inner surface of the cyst also tends not to be nodular.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

Cases of Certain Diseases Reported To the Michigan Department of Public Health For the Five-Week Period Ending May 1, 1970

	1970 THIS 5-WEEK PERIOD	1969 SAME 5-WEEK PERIOD	1970 TOTAL TO ABOVE DATE	1969 TOTAL SAME DATE	TOTAL CASES FOR 1969
Rubella	562	868	1671	1831	4307
Measles	295	32	555	108	401
Whooping Cough	8	9	38	50	192
Diphtheria	—	—	—	—	—
Mumps	932	848	2794	2484	5215
Scarlet Fever & Strep Sore Throat	1620	1323	5699	4509	9763
Tetanus	2	—	3	1	6
Poliomyelitis (paralytic)	—	—	—	—	—
Hepatitis	480	345	1582	1095	3360
Salmonellosis (Other than S. typhi)	63	42	179	144	539
Typhoid Fever (S. typhi)	4	2	5	3	6
Shigellosis	28	25	73	108	300
Aseptic Meningitis	2	6	17	34	179
Encephalitis	9	11	24	32	120
Meningococcic Meningitis	9	18	26	52	114
H. Influenza Meningitis	8	3	26	14	56
Tuberculosis	235	258	745	821	2108
Syphilis	428	474	1315	1608	4021
Gonorrhea	1814	1638	6870	5891	19194

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

Complicated by Thrombocytopenia and Pancreatitis

Midline Lethal Granuloma

BY B. GANDHI, M.D.
G. BAZIL, M.D.
L. KURAN, M.D.
A. OLSON, M.D.

The clinical entity recognized as midline lethal granuloma was first described by McBride[1] in 1897. Eichel and Mabery's[2] statement, "since then it has been a clinical enigma and pathological and therapeutic dilemma" remains valid. The disorder is typically a progressive, ulcerative necrotizing process involving the nose, face, palate and sinuses. The outcome of the disease is invariably fatal.

A case of midline lethal granuloma with long term survival is reported. Thrombocytopenia, pancreatitis and malignant reticulosis are interesting and unusual aspects.

CASE REPORT

A boy 11 years old was admitted to Mount Carmel Mercy Hospital September 28, 1960 with severe rhinitis of two months duration. The rhinitis did not improve with routine management. The patient also had high fever, sore throat, hoarseness and dysphagia. Examination revealed pale granular edematous nasal mucosa with a moderate amount of pus in the nasopharynx and a dirty gray ulcer of the left false vocal cord and aryepiglottic fold. Biopsy of the larynx revealed a non-specific suppurating necrotizing inflammation (**Fig. 1**). After excluding other specific diseases, a diagnosis of midline lethal granuloma was made. Tetracycline 250 mg q.i.d. and prednisone 20 mg q.i.d. were started. The patient improved remarkably with therapy and gained 15 pounds in one month. Development of cushinoid features necessitated reduction in prednisone to 5 mg q.i.d. Any lower dosage resulted in flaring of the symptoms.

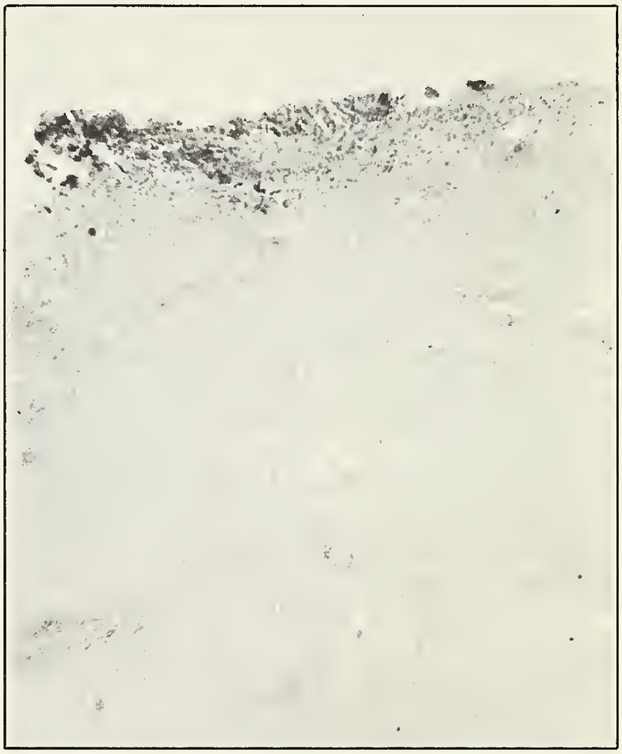


FIGURE 1 Laryngeal biopsy showing necrosis (X155).

In March, 1963 the patient had a sudden exacerbation of symptoms with difficulty in breathing although he was still on maintenance dosage of steroids, 5 mg q.i.d. As signs of laryngeal obstruction increased, tracheostomy was necessary. Steroids were increased and antibiotics were given. Clinical remission in three weeks permitted closure of the tracheostomy. One year later, the patient was absolutely symptom free and prednisone was gradually discontinued. In all, he had four years of steroid therapy.

When the patient was 15 years old, he developed "allergic rhinitis." He did not have foul smelling discharge, epistaxis or loss of weight. Testing with various allergens indicated sensitivity to pollens, grass, fungus and molds. Desensitization therapy was begun with minimal improvement in symptomatology. Steroids were not given during this illness.

In October, 1968 the patient was again admitted to Mount Carmel Mercy Hospital with complaints of nasal obstruction, foul smelling discharge, dysphagia, hoarseness and loss of 15 pounds in three months. Examination revealed ulcerating lesions in the nasal mucosa, pharynx and soft palate. Biopsy revealed a necrotizing granulomatous inflammation (**Figs. 2, 3**) with necrotizing arteritis (**Fig. 4**). He was started on prednisone 20 mg q.i.d and ampicillin 250 mg q.i.d. Symptoms improved

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The authors are all with the Mt. Carmel-Mercy Hospital in Detroit, where Doctor Gandhi is a resident in the Department of Medicine, Doctor Bazil is with the Department of Internal Medicine, Doctor Kuran is with the Department of Surgery and Doctor Olson is with the Department of Pathology.

FIGURE 2 Nasal biopsy showing necrosis (X155).

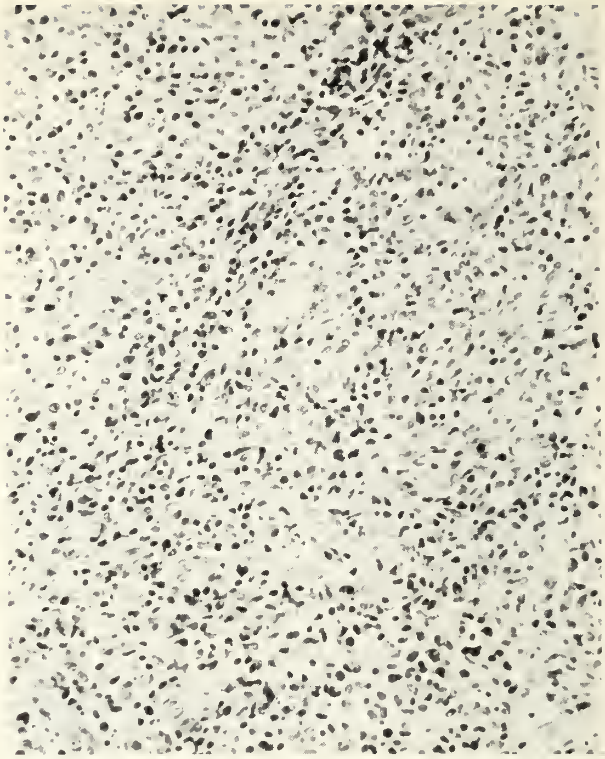

FIGURE 3 Nasal biopsy showing polymorphous inflammatory infiltrate (X250).

in a few days and he was discharged from the hospital. Initially improvement continued but later symptoms recurred. Subsequently, he was given 1000 r cobalt therapy in five days through a single anterior portal of left paranasal sinuses without marked improvement. He was readmitted to the hospital for further management December 6 1968.

During his last admission, prednisone dosage was increased to 30 mg q.i.d. and later to 50 mg q.i.d. The patient complained of tingling and numbness on the left side of the face in the distribution of the trigeminal nerve. Invasion of the destructive process into the cranial bones with nerve involvement was confirmed by roentgenographic examination.

On the tenth hospital day, the patient developed small petechial hemorrhages on both lower extremities. Platelet count was 18,000/ cu mm. Bone marrow examination revealed reactive hyperplasia of all cellular elements including megakaryocytes. The findings were consistent with a pattern of selective thrombocytopenia associated with a state of hyperplenism. At this time, the patient was receiving prednisone 50 mg q.i.d., meprobamate 400 mg q.i.d., tetracycline 250 mg q. 6 hr., seconal 100 mg h.s. and Maalox p.r.n. These medications were discontinued and erythromycin and dexamethasone 0.75 mg, eight tablets q.i.d., were started. As petechiae increased in size and epistaxis developed, platelet transfusions were given. On the 14th hospital day, he complained of epigastric pain. Upper gastrointestinal series for possible peptic ulcer was negative.

On the 24th hospital day, the patient again complained of epigastric pain. Physical examination was unremarkable. On the 27th hospital day, he had severe abdominal pain and subsequently developed shock. Despite treatment with vasopressive agents, he died in four hours.

AUTOPSY

At autospy, the chief gross findings consisted of petechiae and ecchymosis over the lower extremities, moderate bilateral pulmonary congestion, moderate enlargement of the pancreatic lymph nodes and acute pancreatitis. The nose as well as the larynx and trachea failed to show any abnormalities.

Microscopic studies revealed a malignant reticulosis involving the lymph nodes primarily, although the nodes were not enlarged except for the pancreatic adenopathy. All presented a similar histopathology with loss of normal architecture and large cells displaying hyperchromatic nuclei and containing nuclear debris dispersed throughout the nodal tissue and infiltrating the capsule (Fig. 5). Focal areas of necrosis were evident. The

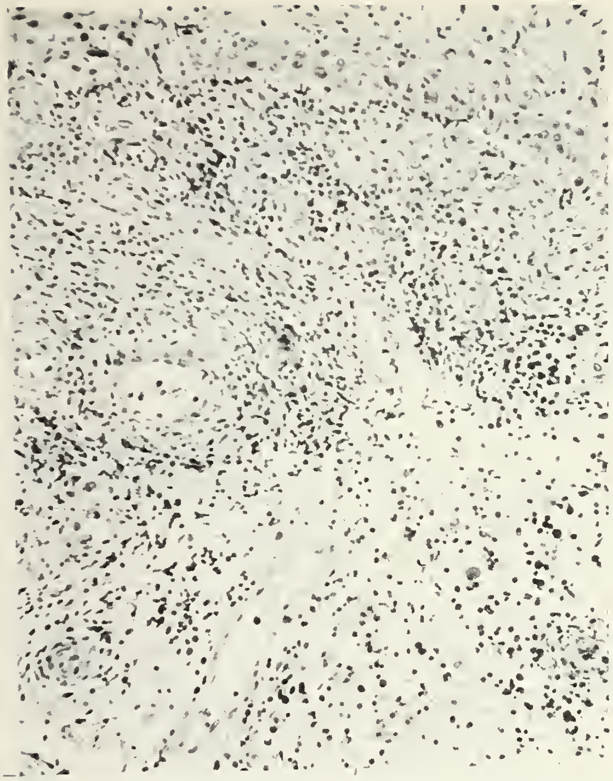

FIGURE 4 Nasal biopsy showing arteritis (X155).

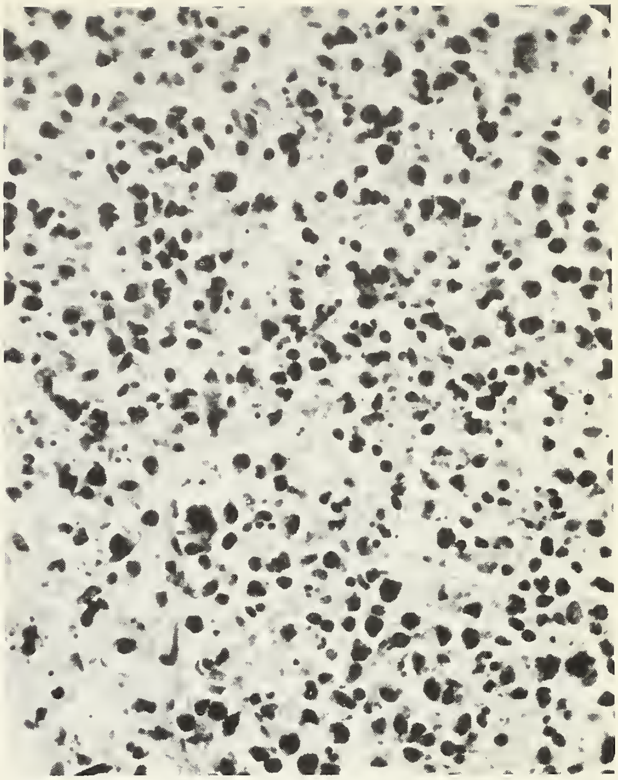

FIGURE 5 Lymph node from autopsy showing large pleomorphic cells and nuclear phagocytosis (X400).

malignant process was infiltrating the pancreas from the lymph nodes with complete loss of the usual histologic pattern of the pancreas in some zones with better preserved areas showing acinar ectasia with inspissated secretion (**Fig. 6**). A few foci of squamous metaplasia were observed in ducts. In the liver, moderate disruption of hepatic cords was seen with mononuclear cells having hyperchromatic nuclei being identified within sinusoids. The splenic pulp also contained similar cells. Multiple sections through the pharynx and larynx showed only minimal submucosal ecchymosis. The kidneys and lungs revealed no granulomatous inflammation or polyarteritis.

DISCUSSION

The inter-relationship between midline lethal granuloma and Wegener's granulomatosis is not clear. Some individuals regard the two entities as one[3-7] while others consider them as two distinct conditions.[2-8] Friedmann[9] separated midline lethal granuloma into two histopathologic categories. The first category, termed "non-healing granuloma of the nose of Stewart type," (midline lethal granuloma) displayed a massive infiltration of the involved area primarily by lymphocytes accompanied by plasma cells and bizarre shaped histiocytes presenting spherical or reniform nuclei. Necrosis was a prominent alteration in the affected areas. The second category, designated "the non-healing granuloma of the nose of Wegener's type" (Wegener's granulomatosis), presented the picture of a necrotizing giant cell granuloma with arteritis affecting the pulmonary and systemic vasculature in the latter phase of the disease. Although tissue necrosis occurs, this feature is never as marked as in midline lethal granuloma.

MIDLINE LETHAL GRANULOMA

Terms used interchangeably with midline lethal granuloma[2] include: malignant granuloma, granuloma gangraenescens, sarco lupo pernio, gangrenous osteomyelitis, idiopathic granuloma of face, facial mycosis fungoides, pseudotumoral inflammation, malignant reticulosis, malignant mesenchymoma, Stewart's syndrome, polymorphic reticulosis, lethal granulomatous ulceration, nonhealing granuloma of nose and mouth, mutilating granuloma and osteomyelitis necroticans.

The etiology of midline lethal granuloma is unknown. Williams and other authors[10,11] include midline lethal granuloma as a collagen disease related to polyarteritis nodosa. Others[12,13] suggest an inflammatory or neoplastic process with various forms of lymphoma and sarcoma being mentioned.

The disease is almost twice as common in men as in women. Cases are more common in early middle age. The most frequent primary site of the

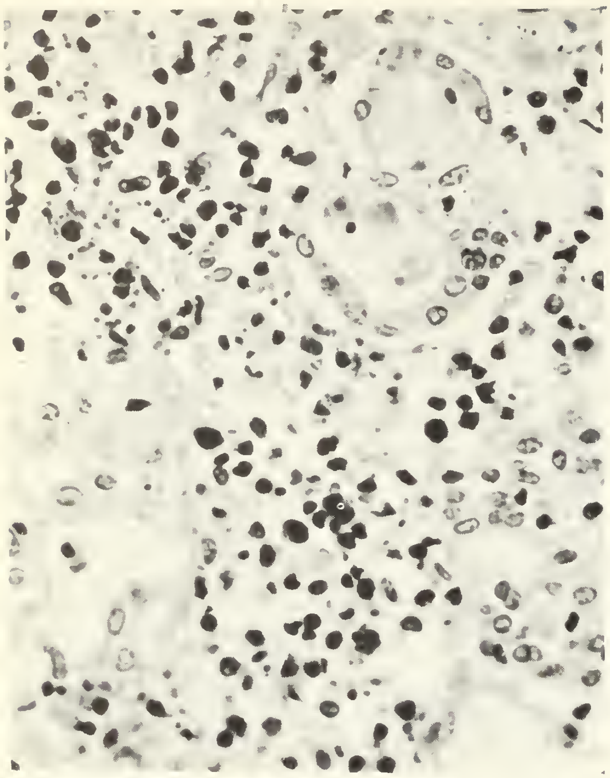

FIGURE 6 Pancreas showing acinar ectasia with inspissated secretion and pleomorphic cell infiltration (X400).

involvement is the nasal cavity with pharynx and palate less often affected.

Clinically, midline lethal granuloma may be divided into three phases as per Stewart (1933),[14] i.e., prodromal, active and terminal stages. Prodromal stage of the disease exhibits intermittent nasal stuffiness, serosanguineous nasal discharge and sinusitis. The first manifestation may be superficial ulceration in the nose and throat. It may last for one or more years. The active stage is heralded by increasing nasal obstruction, a purulent or hemorrhagic discharge from the nose and septic fever. The ulceration tends to spread from the palate to the inside of the nose and from the inside of the nose to the outside. Perforation of the nasal septum may occur. The terminal stage is associated with marked deformity. Finally, death follows from meningitis, septicemia, hemorrhage or pulmonary complications.

Burston[15] comments that a diagnosis of midline lethal granuloma tends to paralyze the physician's initiative in seeking other diagnostic possibilities. The diagnosis of midline lethal granuloma is established only by ruling out other specific diseases such as: tuberculosis, sarcoidosis, mycotic infection, leprosy, lymphoma, Leishmaniasis, yaws, tularemia and granuloma venereum.

In 1941, Hoover[16] described the characteristic histopathology, noting an amorphous mass of necrosis at the edge of the lesion beneath which was an infiltration of inflammatory cells represented primarily by lymphocytes and macrophages with occasional plasma cells. A few polymorphonuclear cells are generally evident. Large vessels exhibit definite perivascular lymphocytic and histiocytic cuffing and degeneration of the arterial wall in some areas. In 1947, Boyd[17] described the microscopic appearance of this lesion as granulomatous inflammation including epithelial cells, giant cells and lymphocytes. Intense necrosis resembling infarction was a prominent finding possibly due to a marked obliterating arteritis which accompanies the condition.

Midline lethal granuloma is a fatal disease. Generally the patient succumbs within a period of two to four and one-half years. Various therapeutic measures have been utilized. Except for a few isolated instances, whenever excision of the necrotic area or heavy radiation were used, the process seemed to be accelerated.[18] Three forms of therapy with some success are (1) steroid, (2) small dose irradiation and (3) antimetabolites. Steroid treatment is commonly employed in this country. Prednisone 80 mg or more is commonly used. X-ray therapy is used mainly in Great Britain. Successful response with irradiation was reported by Glass[19] in 1955 using a total of 900 r in five to six administrations. The interesting report by vonLeden and Schiff[20] offers a new mode of therapy utilizing antimetabolites such as methotrexate and 5-Fluorouracil.

The present case is unusual in several aspects. Prolonged survival is uncommon. Associated thrombocytopenia was disconcerting in view of the high dosage of prednisone. This complication was attributed to drugs, primarily meprobamate and seconal, although malignant reticulosis is a possibility. All medications were discontinued including prednisone but the patient failed to respond favorably. The autopsy findings of malignant reticulosis and pancreatitis were unexpected. In the literature about 12 cases of midline lethal granuloma with reticulosis or lymphoma have been described.[8,12,13,21] Almost all cases were diagnosed at autopsy. Some authors[8,21] tend to give this association a separate name, granuloma gangraenescens. They also believe that if autopsy is very carefully performed, many more cases may be discovered. Granuloma gangraenescens does not seem to arise in the lymph nodes primarily as they are frequently not enlarged but the adenopathy appears to be part of a generalized response.

The cause of death in this case was acute pancreatitis. Whether pancreatitis was induced by steroids or malignant reticulosis is difficult to determine. There was no evidence of obstruction of the pancreatic duct by the process of reticulosis at autopsy. With the microscopic findings of acinar ectasia and inspissated pancreatic secretions

Table 1 illustrates the main clinical differences between the two processes.

Table 1

	MIDLINE LETHAL GRANULOMA	WEGENER'S GRANULOMATOSIS
Premonitary symptoms	Nonspecific	Nonspecific
Progression of disease	Slow in years	Rapid in months
Systemic involvement	Not Common	Lungs and kidneys are always involved
Lungs	Occasional broncho-pneumonia	Nodular densities or cavitation
Kidneys	Normal	Arteritis
Cause of death	Septicemia, hemorrhage, meningitis, pneumonia	Uremia

in ducts and acini, we tend to favor steroids as the cause of pancreatitis. In the literature a few cases of steroid induced pancreatitis show the above mentioned findings.[22]

It was also interesting that at autopsy there was no marked evidence of the midline lethal granuloma. The original disease responded very well to high dosage of steroid therapy, but steroid therapy itself produced pancreatitis which was the cause of death.

SUMMARY

Midline lethal granuloma and Wegener's granulomatosis differ in their course and pathology. Both diseases are diagnosed only after excluding other processes. Therapeutic measures are not very successful and the outcome is fatal.

Reprints may be obtained from A. Olson, M.D., Mt. Carmel Mercy Hospital, 6071 W. Outer Drive, Detroit 48235.

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Perinatal Tips

On this page MICHIGAN MEDICINE presents a new feature prepared at the suggestion of the associate scientific editors.

The following case from the files of the Wayne County Medical Society Perinatal Mortality Committee is presented as an aid in continuing education.

MATERNAL

This was the second pregnancy for a 21-year-old O+ white mother. Her pregnancy was completely uneventful with routine monthly prenatal visits. The prior infant weighed 5 lbs. 13 ozs. at birth and is alive and well. (Parents were Jehovah Witnesses and would not accept blood transfusions but would allow other hospital procedures, such as lab studies, operations, etc.).

FETAL

A 6 lb. 2 oz. white male infant was born in early A.M. at 40 weeks gestation. Cord blood was A Coombs negative and apgar was 5 due to extreme cyanosis and marked respiratory distress. The delivering doctor examined the patient and noted only "dextrocardia" and felt the patient had "congenital heart disease." The infant was placed in an incubator with oxygen and mist. He seemed for a short time to pink up and have noticeably less distress. Because of the early hour (3 A.M.), it was elected to watch the infant. However, cyanosis and respiratory distress returned and within one hour the infant suddenly expired. Post mortem exam revealed diaphragmatic hernia, with herniation of abdominal contents into left pleural cavity.

PERINATAL COMMITTEE COMMENTS

1. Any infant born of an uneventful full term pregnancy and delivery that has a low apgar due to cyanosis and respiratory distress should be fully investigated as soon after birth as possible.

2. Any infant with respiratory distress that does not clear very quickly after suction and oxygen may be a candidate for an immediate chest X-Ray.

PERINATAL TIPS

3. Dextrocardia in an infant with cyanosis and/or respiratory distress should immediately suggest at least three diagnoses:

(1) severe pneumothorax

(2) diaphragmatic hernia of left chest

(3) possible severe congenital heart disease

All three of these need immediate treatment (after confirmatory studies quickly help make the diagnosis.)

Respectfully submitted,
Paul M. Zavell, M.D.
Chairman, Neo-Natal and Hospital Care Committee, Michigan Chapter, A.A.P.
Chairman, Perinatal Mortality Study Committee, Wayne County Medical Society

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INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

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msms news

Michigan Mediscene

May 29-June 11—Michigan Association of the Professions Congress at Sea

June 3-6—Wayne County Healthorama, Outer Drive Hospital, Lincoln Park

June 4—MARMP Professional Advisory Council on Cancer, 1:30 p.m., MSMS Headquarters, East Lansing

June 10—MARMP Board Meeting, 1:30 p.m., MSMS Headquarters, East Lansing

June 15-17—Blood Transfusion Therapy and Related Immunology, American College of Physicians, Kellogg Center, East Lansing

June 16-18—State Board Examinations for medical licenses, Lansing Civic Center

June 17—MSMS Special Council Meeting, MSMS Headquarters, East Lansing, noon

June 18—Annual University of Michigan-Michigan State University Cardio-Vascular Research Seminar

June 18-20—Upper Peninsula Medical Society 75th Annual Meeting, Sault Ste. Marie

June 19—1970 Annual Scientific Session of the Allied Health Professions Section of The Arthritis Foundation, Detroit Hilton Hotel, Detroit

June 19-20—1970 Annual Scientific Session of the American Rheumatism Association Section of The Arthritis Foundation, Detroit Hilton Hotel, Detroit

June 21-25—Many Michigan physicians will participate in the AMA Convention in Chicago

June 29-July 1—Michigan Association of General Practitioners Annual Postgraduate Clinic, Boyne Highlands Lodge

July 23-25—MSMS Midsummer Session of The Council, Grand Hotel, Mackinac Island

July 30-31—50th Annual Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City

Sept. 20—MSMS Council, Sheraton Cadillac Hotel, Detroit, 9:30 a.m.

Sept. 20-24—MSMS Annual Session, Sheraton Cadillac Hotel, Detroit

Sept. 23—MSMS Council, Sheraton-Cadillac Hotel, Detroit, 8 a.m.

Sept. 23-24—Annual Convention of Woman's Auxiliary to MSMS, American Association of Medical Assistants, State of Michigan

Sept. 26-27—Annual Fall Educational Seminar, Michigan State Medical Assistants Society, The Campus Inn, Ann Arbor

Oct. 5-9—53rd Annual Meeting, American Dietetic Association, Detroit

Oct. 5-19—MSMS Orient Adventure

Oct. 16-17—Michigan State Association of Industrial Nurses Fall Conference, Holiday Inn, St. Joseph

Nov. 4—Special meeting of The Council, MSMS Headquarters, East Lansing, noon

Nov. 9-13—International Drug Abuse Symposium sponsored for practicing physicians by the University of Michigan, Towsley Center, Ann Arbor

Nov. 11—Michigan Cancer Coordinating Committee, MSMS Headquarters, East Lansing, noon

Nov. 29-Dec. 2—Many Michigan physicians will participate in the annual AMA Clinical Convention in Boston

Dec. 9—MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

MSMS Assisting In Pilot Project For Medical Students

MSMS and the Michigan Hospital Association are cooperating in a pilot project this summer to place students from Michigan's three medical schools in Michigan hospitals for clinical experience.

The MSMS Council approved the project of the Student American Medical Association project at its April 22 meeting. MSMS officials and staff members will work with component society leaders and directors of medical education and medical chiefs of staff on the project.

The project was initiated last year in Illinois and will be expanded this year to seven states, with Michigan being the second. SAMA hopes to have the project nation-wide in three or four years.

SAMA leaders hope that 10-15 Michigan hospitals will participate this summer, accepting 15-20 freshman and sophomore medical students in individually-oriented, educational programs in community hospitals, stressing exposure to clinical situations and hospital operations. In each program, students will rotate through a series of clinical and non-clinical areas of the hospital under the direct supervision of physicians.

Tom McNett, sophomore in the Michigan State University College of Human Medicine, is project director for the state. Interested physicians may address a letter to the Education Liaison Committee, MSMS, Box 950, East Lansing 48823.

Meeting of April 22, 1970

MSMS Studying Required PG Education

PG Requirements — The Council authorized the Committee on Postgraduate Medical Education to study the establishment of minimum standards for continuing medical education as a requirement for membership in MSMS or for continued re-registration in Michigan.

State Boards — The Council respectfully urged the State Board of Registration in Medicine to attempt to find a suitable location in Detroit instead of Lansing to hold the FLEX examination, at the request of Wayne State University students who are the majority preparing to take the exams.

M. A. Riley — The Council gave MSMS Legislative Counsel M. A. Riley, who recently resigned, a rising vote of thanks for his dedicated work in behalf of medicine during 10 years with MSMS. Council Chairman Ross V. Taylor, M.D., Jackson, personally and in behalf of the Council wished Mr. Riley all success in his new opportunity as assistant director, Department of Field Services, Public Affairs Division, for the AMA. Mr. Riley will be based in Portland, Ore.

MDMH Director — The Council made a general recommendation to the governor that any future director of the Department of Mental Health be a doctor of medicine and a psychiatrist.

RVS Booklet — The Council re-referred the publishing of a standardized listing of codings of procedures for further study and report to the County Societies Committee in the light of changing medical socio-economics.

WSU School of Medicine — The Council urged proper financial and administrative support of Wayne State University School of Medicine in order for it to achieve its growth, expansion and planned development.

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Physicians Urged To Study Portion Of Himler Report

The MSMS delegates to the AMA House of Delegates have urged that a portion of the Himler Report discussing federal health programs "should be widely publicized to the profession."

The Himler Report, in part, states, "it is safe to say that unless the private sector can propose effective solutions to existing problems, the next decade will see us moving in the direction of vastly broadened assumption of authority and responsibility by government, with a concomitant increase in public dependence on assistance programs."

The report goes on: "Ironically, the organization necessary to satisfy the newly aroused public impatience for better living conditions, more government guarantees, and greater security is almost totally lacking. Most federal government programs of recent vintage, since they were created in response to pressure or crisis, were hastily enacted with insufficient regard for their cost or their feasibility in terms of facilities, administrative mechanisms, and professional manpower.

"In addition, partly because differences in local conditions, needs, and facilities dictated that planning begin on a local level, partly out of deference to states' rights, and partly because central administration of massive new programs was not immediately practical, recent social welfare laws have been limited by Congress to the provision of grants-in-aid or matching funds. Implementation of the programs has been 'left to the states within fairly loose frameworks of conditions, standards, and criteria. Usually, to stimulate the states into prompt compliance, the laws set time limitations on program activation."

"Most states, anxious not to lose their share of federal largesse, passed hasty, and often ill-conceived, implementing legislation, and then placed their reliance on local and municipal governments to put the programs into operation. The resulting confusion has seriously impaired the new programs and has brought about frictions and damaging waste of limited human and financial resources.

"In the general confusion, state and local legislators, administrators, and a new corps of government advisors have busily elaborated a great variety of favorite theories, plans and procedures, which, when translated into action, have proved to be costly and ineffective."

SAMA Project — The Council approved MSMS cooperation with the SAMA chapters at the three Michigan medical schools and the Michigan Hospital Association to carry on the SAMA summer medical student placement program on a limited basis in 1970.

Physicians' Aid — The Council approved the idea of a long-range plan to create a permanent and separate fund to aid needy physicians on a member-benefit basis. It authorized an ad hoc committee led by MSMS Treasurer John R. Ylvisaker, M.D., to develop funding alternatives for setting up the plan.

Osteopathic School — The Council authorized Chairman Ross V. Taylor, M.D., to appoint an ad hoc committee to meet with MSU College of Human Medicine leaders to discuss the precise position of the plans for the integration of the Pontiac-located Michigan School of Osteopathy into the MSU College of Human Medicine.

California Conference — The Council approved sending a delegation to a California meeting in May, to gather information about the California Medical Foundations which take over the operation of the Title 19 program within a specific area.

Lay appointments — The Council went on record as opposing the placing of lay people on professional licensing boards.

Leadership Meeting — The Council approved MSMS sponsorship of a workshop May 20 for MSMS officers to bridge a public speaking seminar May 20 and a one-day conference on critical health problems education sponsored by the Michigan Health Council in Lansing May 21.

Maternal Health — The Council accepted the first preliminary study on perinatal mortality in Detroit; recommended that prenatal care be included in the Title XIX benefits for categorically and medically indigent mothers in the State of Michigan, whether rendered by private physicians or properly organized obstetrical clinics according to the patient's choice; and approved the proposed placental tissue registry at Michigan State University as a continuing project of the MSMS Committee on Maternal and Perinatal Health.

Clara Elizabeth Fund — The Council voted to send a letter of thanks to the Clara Elizabeth Fund of Flint for its sponsorship of the annual Maternal and Perinatal Health Conference, and urging it to sponsor a 1971 conference.

Computer Technology — The Council authorized the Committee on Postgraduate Medical Education to write to the AMA Board of Trustees urging that an ad hoc committee on computer technology and medical practice be appointed and its work moved forward.

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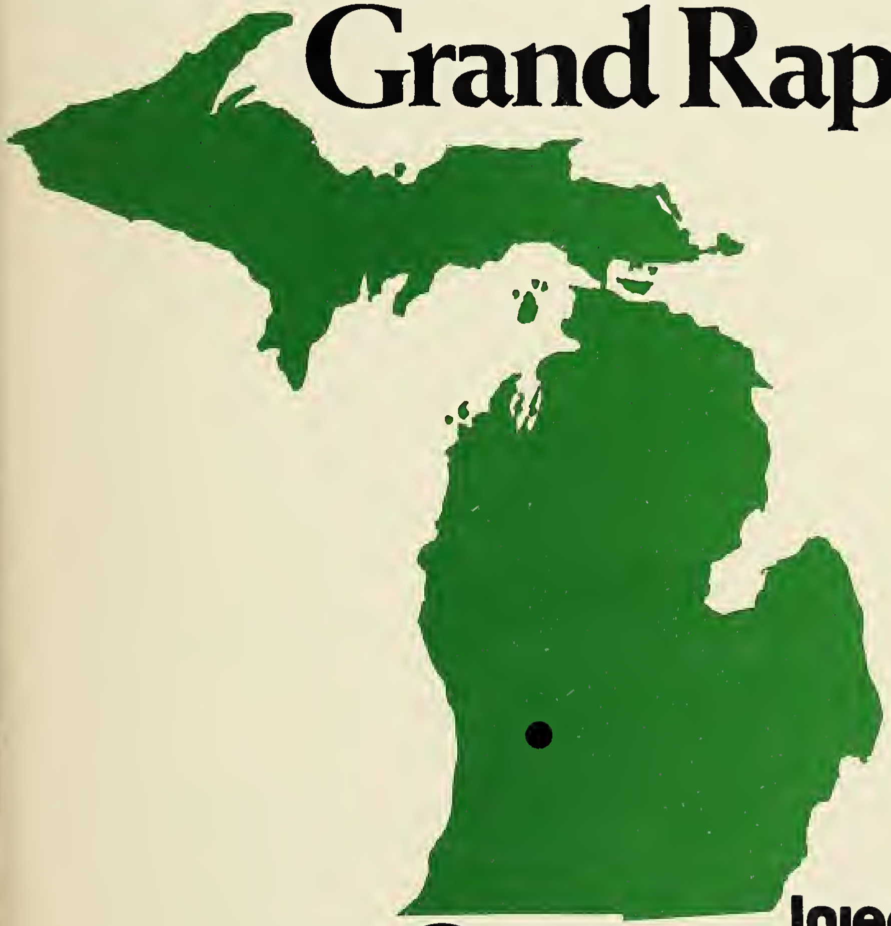

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See Clinical Considerations section on last page...

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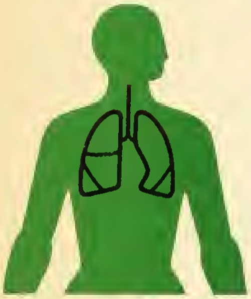

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Outstanding results in serious gram-negative respiratory infections[1,2]

GARAMYCIN Injectable may prove successful where other antibiotics have failed.

Urinary Tract Infections

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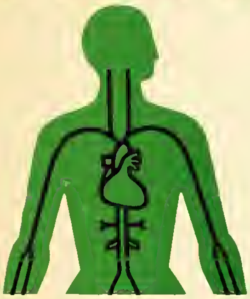

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May be lifesaving[4-6]

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Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

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Mounting evidence in the laboratory...

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Over 95% gram-negative pathogens sensitive.*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.

n a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Antibiotics*

Percentage of sensitive strains
Number of strains tested

Pathogens	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	**99.5%** 962	**84.7%** 992	**86.2%** 995	**76.1%** 67	**32.7%** 1,020	**96.3%** 640	**82.9%** 1,028	**77.1%** 1,026
Aerobacter aerogenes	**95.9%** 2,739	**86.1%** 2,818	**53.5%** 2,985	**58.8%** 1,514	**22.7%** 3,066	**88.6%** 2,603	**85.8%** 3,071	**67.8%** 2,981
***Klebsiella* aerobacter group**	**98.8%** 566	**83.9%** 547	**66.1%** 522	**60.5%** 276	**28.0%** 553	**89.5%** 560	**86.2%** 587	**62.8%** 433
***Klebsiella*, all others**	**92.7%** 2,944	**83.3%** 3,186	**77.4%** 2,976	**67.5%** 627	**13.5%** 2,883	**95.0%** 2,105	**81.6%** 3,212	**70.6%** 3,063
Pseudomonas aeruginosa	**91.6%** 4,528	**29.8%** 4,460	**6.6%** 4,418	**6.6%** 1,279	**6.0%** 4,360	**91.3%** 3,852	**26.9%** 4,608	**26.4%** 4,404
***Proteus*, indole-positive**	**91.8%** 1,031	**85.8%** 1,062	**39.9%** 981	**54.1%** 364	**40.2%** 1,042	**10.3%** 758	**76.1%** 1,096	**42.1%** 1,051
***Proteus mirabilis*, indole-negative**	**94.9%** 3,272	**90.1%** 3,378	**83.1%** 3,290	**77.5%** 975	**78.0%** 3,274	**8.8%** 2,634	**85.9%** 3,469	**26.8%** 3,278
***Proteus*, unspecified**	**96.2%** 1,335	**85.8%** 1,371	**71.7%** 1,434	**70.0%** 647	**64.7%** 1,435	**11.2%** 1,233	**76.0%** 1,421	**22.4%** 1,298
Escherichia coli* and all other *Escherichias	**96.4%** 12,557	**91.4%** 12,818	**87.8%** 12,686	**88.8%** 4,251	**74.6%** 12,899	**95.4%** 10,623	**94.1%** 13,086	**70.0%** 12,559
***Paracolobactrum*, all**	**93.4%** 303	**88.9%** 325	**62.0%** 305	**74.2%** 62	**43.8%** 340	**80.9%** 215	**87.1%** 350	**72.6%** 340
Coliform bacteria	**99.0%** 593	**91.2%** 649	**81.5%** 637	**66.7%** 21	**52.7%** 624	**95.6%** 607	**91.6%** 678	**76.1%** 637
Totals	**95.1%** 30,830	**80.5%** 31,606	**65.3%** 31,229	**68.1%** 10,083	**50.3%** 31,496	**75.8%** 25,829	**79.7%** 32,606	**56.5%** 31,070

Gram-positive **(included for consistency with Package insert, not an approved indication)**

Pathogens	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Staph—*S. aureus*, coagulase-positive	**97.4%** 1,548	**88.8%** 1,458	**97.7%** 2,050	**98.7%** 636	**61.1%** 1,559	**20.4%** 628	**94.4%** 2,123	**83.7%** 1,966
Staph—*S. aureus*, unspecified	**99.3%** 993	**92.8%** 902	**98.1%** 1,289	**95.3%** 213	**45.8%** 1,153	**29.3%** 116	**96.4%** 1,427	**82.3%** 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).[8] Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.

Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.

Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.

It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable
Garamycin®
brand of
gentamicin sulfate injection

See Clinical Considerations section on last page...

Injectable Garamycin®
brand of
gentamicin sulfate injection

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)

	Less Severe	**Resistant/ Moderately Severe**	**Serious/Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those wi pre-existing renal damage, treated with GARAMYCIN Injectab usually for longer periods or with higher doses than recommend

GARAMYCIN Injectable is potentially nephrotoxic, and th should be kept in mind when it is used in patients with pre-existi renal impairment. Kidney function diminished by infection of t upper urinary tract may, however, improve during effective trea ment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such streptomycin and kanamycin or of potentially nephrotoxic dru such as polymyxin, colistin, and kanamycin with gentamicin sulfa has not been shown to afford any clinical advantages and, moreov may result in additive toxicity. Monitoring of vestibular, cochle and renal function will provide guidance for therapy in such cas

Precautions: In patients with impaired renal function in who serious infection develops, serum concentrations of the drug m rise, with consequently increased risk of ototoxicity. In these p tients or in those in whom recommended dosage or duration therapy must be exceeded as a life-saving measure, routine studi of kidney function should be performed when possible. These m be supplemented by evaluation of the vestibular and auditory fun tion and measurement of serum concentration of the drug wh feasible. Serum concentrations of gentamicin should be maintain below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to days or be repeated unless required for serious infection not sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectab may occasionally result in overgrowth of nonsensitive organisms. superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity nephrotoxicity have not been established. Studies in pregnant a mals have not revealed teratogenic or ototoxic effects in the fet GARAMYCIN Injectable should not be used in pregnant patients in women of childbearing age unless its use is deemed advisa by the physician.

Adverse Reactions: The overall incidence of ototoxicity consider related to treatment with GARAMYCIN Injectable was 2.8 per ce (16 of 565 patients). Contributory factors (two or more factors we relevant to most patients) were as follows: 10 had azotemia, received a total of 1 gram or more of the drug, 7 had recently r ceived other potentially ototoxic antibiotics (streptomycin or kan mycin), and 5 were over 60 years of age. Six also had decreas high-tone hearing acuity, which returned to or toward normal the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients show increases in BUN that were probably related to treatment wi GARAMYCIN Injectable. Of 20 increases probably or possibly relat to treatment, 7 were reversible, 9 occurred in terminal patients, a 4 had no follow-up.

Other adverse reactions associated with treatment were one instan each of urticaria, decreased hematocrit, and reversible depressi of granulocytes with normal bone marrow. Other rarely report and possibly treatment-related adverse reactions were anemia, i creased reticulocyte count, rash, purpura, drug fever, hypotensio convulsions, twitching, salivation, nausea, vomiting, increased tran aminase activity (SGOT or SGPT), increased serum bilirubin, d creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-do vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin gram-negative urinary and pulmonary infections, Arch. Int. Me *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., a Smith, J. K.: Gentamicin in the treatment of pulmonary infectio J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a ne aminoglycoside antibiotic: Clinical and laboratory studies in urina tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clinic experience with gentamicin, data from 12 German clinics, in Ge tamicin: First International Symposium, Paris, January 196 Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Labor tory and clinical investigation of gentamicin, *ibid.,* pp. 62-74. (Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, H Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nationwi hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachuset (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommend in Package Insert.

For more complete prescribing details, consult package insert Physicians' Desk Reference. Schering literature is also availab from your Schering Representative or Medical Services Departme Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28 S-0

IN ASTHMA
IN EMPHYSEMA

optional therapy

*

THE mudranes®

All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinaations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

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First choice

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When ephedrine is too exciting
or is contraindicated

MUDRANE GG
During pregnancy or when K.I. is
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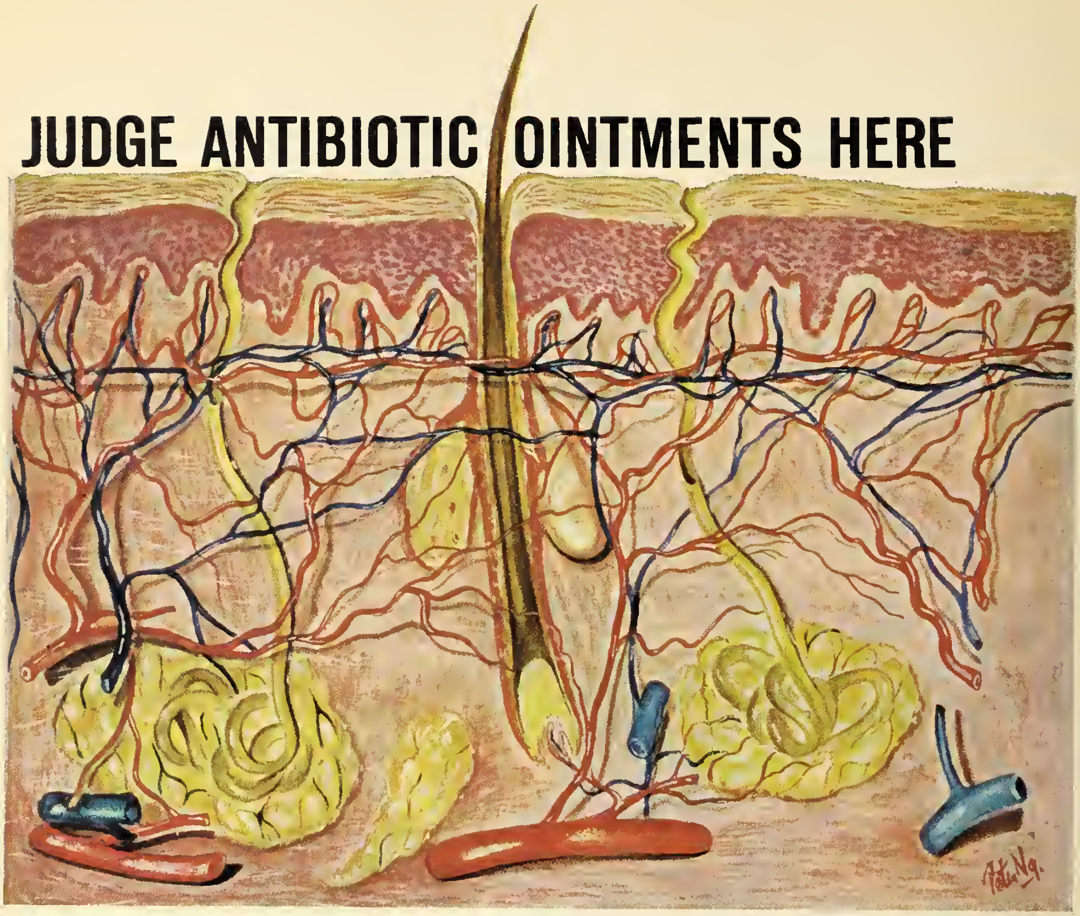

Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B – bacitracin – neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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In dermatologic disorders...

the advantages of ALLERSONE OINTMENT in dermatologic disorders

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IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE
OINTMENT
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COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain—while hydrocortisone reduces inflammation—in a water-washable vehicle—no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.

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medical care programs

News About CHP, Medicare, Medicaid

BY HERBERT MEHLER
STAFF ASSISTANT
MSMS COMMITTEE ON
GOVERNMENTAL-MEDICAL PROGRAMS

STATE CHP ACTIVITY CONTINUES

The March, 1970 *Michigan Medicine* issue previewed the Advisory Council's consideration for recommending the development of legislation to franchise health facilities, including mental health facilities, according to the principles developed by the Task Force on Health Care Costs, Organization and Delivery of Health Services.

Governor Milliken has now been officially requested by the Comprehensive State Health Planning Commission to consider such legislation.

The following principles as proposed by the Task Force and adopted by the Advisory Council require that:

(1) A health facility obtain prior approval from the areawide planning agency before proceeding with new development and such development must be consistent with a state plan. In such a case, a certificate of necessity approving such development will be issued by the State to the facility.

(2) All health facilities should be included within the franchising authority on hospitals, nursing homes, homes for the aged, mental health facilities, neighborhood health centers and all other organized outpatient services, with the exception of offices for the private practice of medicine or dentistry, non-profit corporations established to provide joint or cooperative centralized services to health facilities, and county medical care facilities.

(3) The Comprehensive State Health Planning Advisory Council would act as an appeal body and, if necessary, further appeal could be made to a Circuit Court.

ITEMS OF INTEREST

Medicaid Capitation Project Proposal: Two officials of the state agency met recently with representatives from the Community Health Association, Metropolitan Hospital, UAW, Department of Health of Detroit, and the Michigan Department of Public Health to discuss this proposal prepared by Community Health Association. This project includes preventive services and the proposal has been transmitted to the State Department of Social Services for review and consideration.

CHP Relationship With MARMP: Doctor Heustis met with CHP staff recently to discuss this relationship between the two agencies and it was agreed that such relationships be maintained at the staff level primarily with exchange of communications and documents relevent to both agencies.

Relationship With Michigan Association Community Health Services, Inc. (MACHSI): CHP staff met recently with representatives of MACHSI to exchange information on the work being done by the health officers organization and the Office of CHP.

Medicaid — CHP Task Force on Health Care Costs, Organization and Delivery of Services: Major issues discussed recently with Doctor J. K. Altland, Director of Medical Services, Michigan Department of Social Services were: (1) the Medicaid program has some serious gaps in benefits such as dental care and glasses, (2) the majority of poor people between the ages of 21 and 65 are not served by this program, (3) a health system is needed that is responsive to the needs of the people where they can get care regardless of their ability to pay, (4) effective use of health manpower is a key to the provision of health services to the poor, and (5) nursing home care for psychiatric patients needs further definition.

The proposed work program includes exploration of: (1) health care needs of the age group 21-64, (2) new methods to improve the delivery of health service, including better utilization of health manpower — group practice is one method to be considered and (3) reimbursement policies of agencies regarding the provision of ambulatory and inpatient benefits. In this meeting consumers voiced their opinions on community control and management of health service.

An excellent digest of the Michigan program for Comprehensive Health Planning, F.Y. 1970 detailing authority, policies and procedures, development of a state health plan and work program is available at your request by writing MSMS.

(The above information was excerpted from material distributed by CHP)

From Washington: HEW Secretary Finch's Task Force on Medicaid and Related Programs submitted interim recommendations now under study for administrative and legislative action. Proposed amendments to the Social Security Act are being prepared which may contain the following:

> Establishment of state Medicaid effectiveness systems designed to control utilization, payments, appropriateness of care, data flow, efficiency, etc. Essential to such systems would be national minimum standards for evaluation of these and other factors, developed in partnership with the private sector, and action indicated when the standards are not met.
>
> Financing programs creating demand for services should assume responsibility for supply of services. Five percent of the Medicaid funds (and potentially of Medicare and private insurance) should be earmarked for the development and improvement of health services and resources.
>
> Federal health programs should encourage less costly alternatives to inpatient hospital and nursing home care. Incentives should be paid to States for successful development and use of ambulatory care services.
>
> Other recommendations relate to standard setting, surveying, medical review, and education and information.

Congressional Action: Authority for the Comprehensive Health Planning and Services programs expires on June 30, 1970. A legislative proposal by the Administration combines CHP, the Regional Medical Program, and the National Senate for Health Services Research and Development under a single title and extends the authority for three years. Each will continue as an individual program with separate appropriation authorization as outlined in the proposal entitled "Health Services Improvement Act" designed to emphasize and focus efforts to develop improved health care delivery systems. The bill calls for:

> A common statement of purpose, a single advisory council, and a single annual progress report for the three programs.
>
> Increased coordination with other federal health programs (i.e. Medicare and Medicaid) with particular attention to the relationship between the organization and delivery of health services and their financing.
>
> Experiments in the development of health delivery systems utilizing the capabilities of the Comprehensive Health Planning programs and the Regional Medical programs in a variety of arrangements.
>
> Development of a Federal-State-local health information system.
>
> Authorization of such sums as may be necessary.

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- Medico-Legal counsel.
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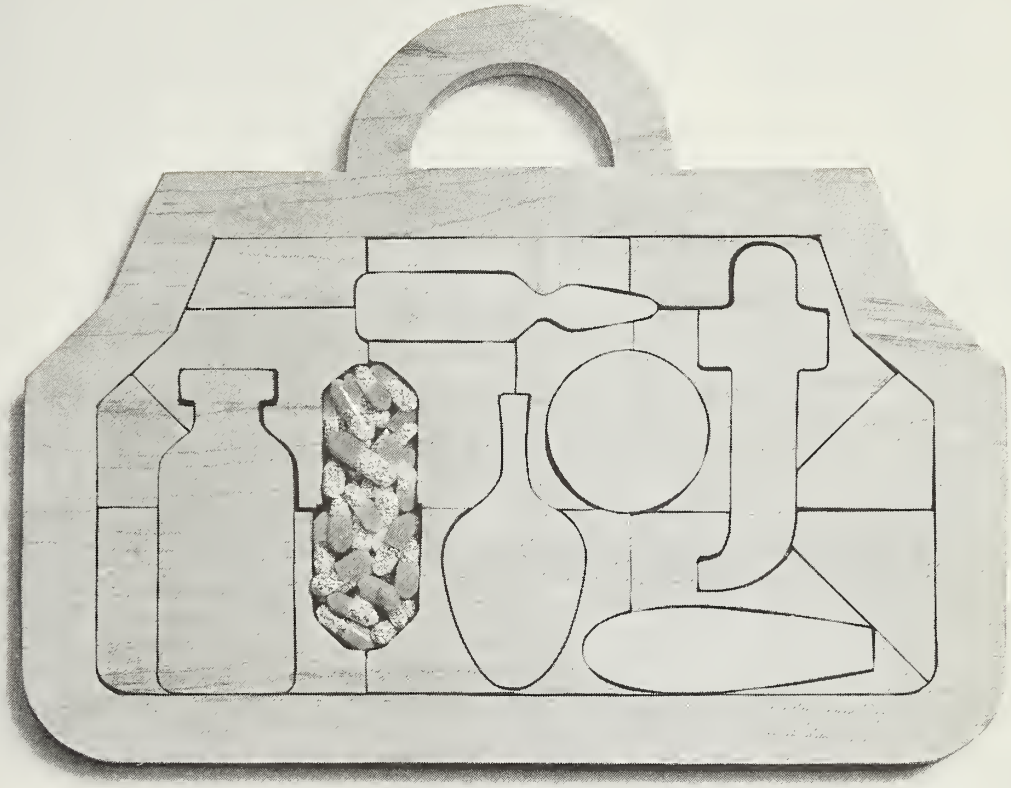

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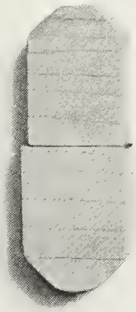

Health Careers Forum Draws Youth, Adults

HIGH SCHOOL STUDENTS, parents and teachers attended the Health Careers Forum sponsored by MSMS, the Wayne County Medical Society, the Michigan Health Council, **The Detroit News** and other groups in Detroit April 25. The excellent AMA film, "Horizons Unlimited," opened the program, which included several short presentations and a panel discussion.

FOLLOWING THE FORUM, MSMS was the host for a special luncheon program honoring about 25 of the winners of the Detroit area Science Fairs. Edward W. Green, M.D., left, representing the Michigan Heart Association, and MSMS President Robert J. Mason, M.D., right, chatted with some of the students receiving special MHA awards.

PRESIDING AT THE FORUM was James Fryfogel, M.D., left, president of the Wayne County Medical Society. Short presentations were made by, next from left, Michael S. Newash, of the Dow Corning Center for Aid to Medical Research and Vic Wertz, former Detroit Tiger. Louis F. Hayes, M.D., right, vice president for medical affairs, Michigan Medical Service, represented Michigan Blue Cross-Blue Shield which helped support the forum.

EIGHT YOUNG ADULTS described why they have chosen the health field as a highlight of the Health Careers Forum at the Detroit Rackham Building. Left to right are Jo Ivey, medical student, University of Michigan; Betty Ann Hoffman, partially hidden, a Detroit medical assistant; Sue Ellen Bordwell, medical social work student, WSU; Martha Garrels, Oakwood Hospital intern in medical technology; James Pipp. physical therapy student, Rehabilitation Institute; Ken Hekman, medical student, WSU; Michael Goldman, dental student, University of Detroit, and Joyce Foster, nursing student, WSU.

PROTEIN CONTENT / 7 oz. Serving*

Bean with Bacon	6.8	Green Pea with Ham (Frozen)	7.6
Beef	8.0	Hot Dog Bean	8.4
Chicken Broth	5.5	Pepper Pot	6.1
Chicken 'N Dumplings	5.8	Split Pea with Ham	10.2
Chili Beef	6.2	Vegetable Beef	5.0
Green Pea	6.9	Vegetable with Beef (Frozen)	5.4

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(when her
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Flagyl® brand of metronidazole

Cures Trichomoniasis in Both Women and Men

About half of all husbands of infected women harbor *Trichomonas vaginalis.**

Few of these men have symptoms. Even so, all are capable of perpetuating the infection and rendering treatment of a woman alone futile.

Only a systemically active medication like Flagyl is capable of reaching the hidden reservoirs of infection in the genitourinary tracts of both men and women.

Only Flagyl has been able to achieve rates of cure consistently above 90 per cent and often up to 100 per cent in trichomonal infections in both men and women.

Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms:	Oral tablets . . .	250 mg.
	Vaginal inserts . .	500 mg.

*References available on request.

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Research in the Service of Medicine

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

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Owner Breaks Arm When Yacht Runs Agroun

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm

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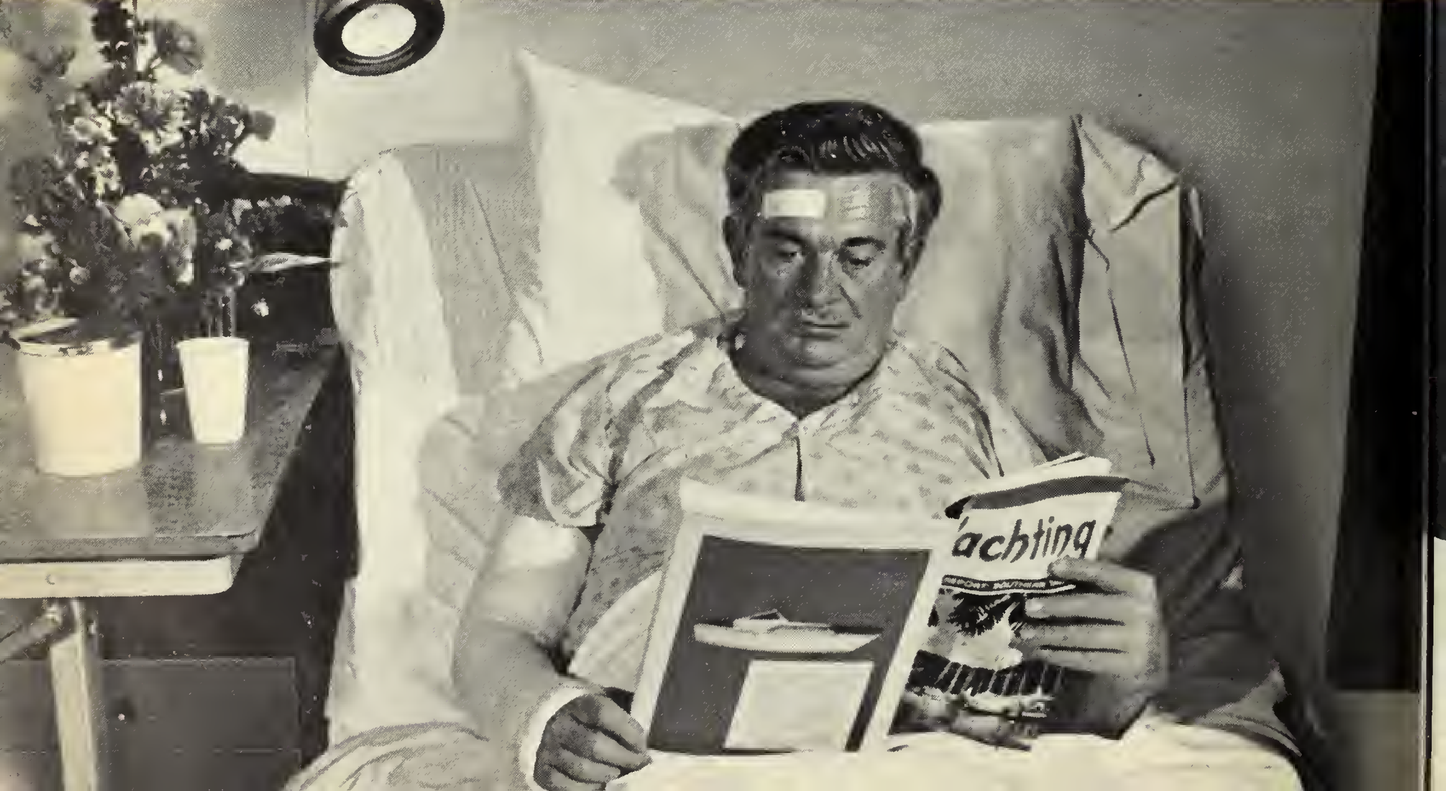
Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



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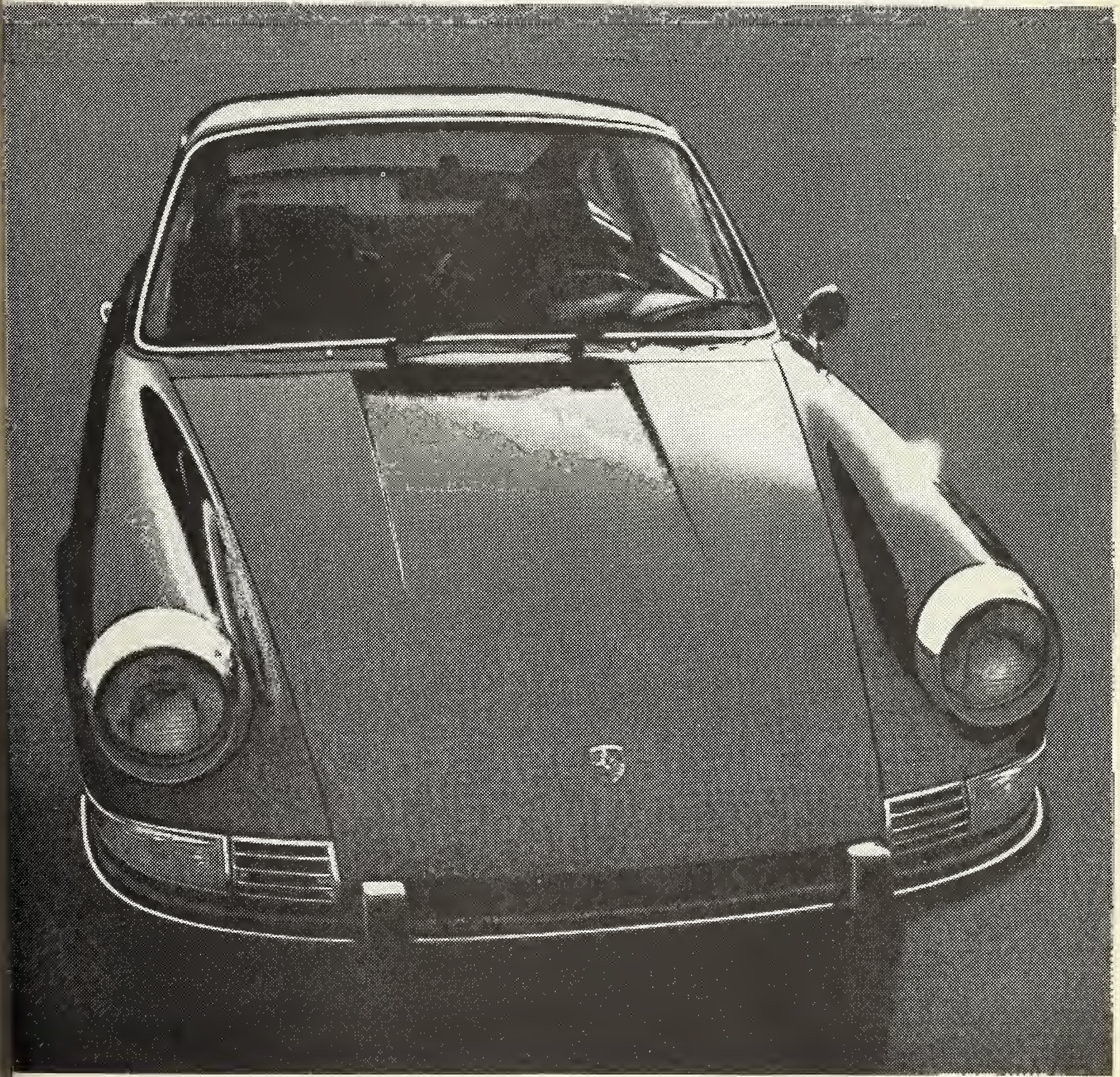

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Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
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PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

W-C PRECISION PHARMACEUTICALS

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WALKER, CORP & CO., INC.
Syracuse, New York 13201

Here is Form For Written Disclosure Of Patients' Payments

Michigan physicians are reminded that their responsibility for written disclosure will, when required, be a very simple one-time matter under the federal Truth in Lending Act requirements.

The act became operative July 1, 1969, affecting some physicians. Then a letter from Paul R. Dixon, chairman of the Federal Trade Commission, to Sen. Charles E. Goodell, (R.-NY.) clarified the effect of the regulation on the medical profession.

Said Mr. Dixon in his letter:

"The Truth in Lending Act does not come into play in a situation in which the patient decides on his own to pay his bill in installments. However, when a physician comes to a specific agreement with a patient to pay the physician's fee in more than four installments, then the regulation requires written disclosure of all applicable points of information at the time of the agreement. This will . . . be a very simple matter. . ."

"The following brief disclosure would satisfy the Truth in Lending Act:

SAMPLE DOCUMENT

Cash Price (medical fee)	$500
Less: Cash Down Payment (Advance Payment)	100
Unpaid Balance	400
Amount Financed	400
Finance Charge	**NONE**
Total of Payments	400
Deferred Payment Price	500
Annual Percentage Rate	**NONE**

Purchaser hereby agrees to pay to Dr. John Doe at the address shown above the "Total of Payments" shown above in 10 monthly installments of $40.00, the first installment being payable ______________________, 19____, and all subsequent installments on the same day of each consecutive month until paid in full.

The two items **finance charge** and **annual percentage rate** must appear in boldface type or otherwise conspicuously, AMA attorneys emphasize.

According to Mr. Dixon's directive, the "use of the above form could be effectuated by any physician's nurse in a few moments and no other disclosure is required on subsequent billings."

(The above is excerpted from the American Medical News, Oct. 13, 1969.)

The Doctor's Income Tax Calendar

July 1 — File a renewal application for your federal narcotics tax stamp. Include an inventory of narcotics on hand. Mail these, together with a check for $1, to your District Director of Internal Revenue.

July 15 — If your contributions to your employes' Social Security plus the Social Security and income taxes withheld from their salaries exceed $100 in June, complete Form 501 and pay the taxes.

July 31 — Pay the balance of your second-quarter contributions to your employes' Social Security, plus Social Security and income taxes withheld from their salaries from April 1 through June 30; file Form 941. If the taxes exceeded $2,500 in any month of the preceding quarter, you must now remit semimonthly.

Aug. 17 — If your contributions to your employes' Social Security plus the Social Security and income taxes withheld from their salaries exceeded $100 in July, complete Form 501 and pay the taxes.

Sept. 15 — Pay the third installment of your 1970 Federal tax (one-fourth of your estimated income tax and one-fourth of your Social Security tax of $538.20). If your taxable income so far this year varies 10 per cent or more from your last estimate, it's advisable to file an amended 1040-ES. If your contributions to your employes' Social Security plus the Social Security and income taxes withheld from their salaries exceeded $100 in August, complete Form 501 and pay the taxes.

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With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

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A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): 1/2 tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C PRECISION PHARMACEUTICALS

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Physicians Urged to Fight For Environmental Quality

Doctors, individually and collectively, can improve environmental quality, a panel of three physicians and a medical scientist said at a recent Michigan State University "teach-out."

The program, arranged by MSU medical students for Lansing area physicians and other health professionals, was part of the university's Environmental Teach-In.

Speakers were Maurice S. Reizen, M.D., director of the Michigan Public Health Department; William B. Weil, Jr., M.D., chairman of the Department of Human Development at MSU; John L. Isbister, M.D., associate director of the Michigan Department of Public Health; and James E. Trosko, M.D., assistant professor of human development and of Justin Morrill College. The panel was moderated by Andrew D. Hunt, Jr., M.D., dean of the MSU College of Human Medicine.

Doctor Reizen said physicians should acknowledge that the population explosion is a problem in the United States. They should educate themselves and others, he said, and attempt to divorce the problems from personal, emotional bias.

"ENCOURAGE POPULATION CONTROL in the office, in the hospital, in the home and in the political arena," he urged.

He requested physicians to remove archaic restrictions on population control whenever feasible, and to aid in revision of national priorities.

"Do we really want more highways for automobiles to put out more pollution," he asked, "or do we want some kind of mass transit system which would reduce the amount of pollution considerably."

Doctor Weil said physicians should lobby for improved government food programs. Nationally, he noted, there are 30 million poor Americans but only one-quarter are getting food stamps or surplus commodities.

PHYSICIANS SHOULD BE ALERT to food habits leading to malnutrition or obesity. He advised doctors to counsel patients with nutritional problems and to be aware of ways in which food is often used to satisfy emotional and social needs rather than hunger.

Doctor Isbister urged physicians to be alert to problems caused by modern technology going awry and producing undesirable side effects.

As an illustration, he noted that people attending a swank party became ill after drinking champagne. The cause was traced to a pump being used to cascade champagne into the serving bowls. Part of the plating had worn off the pump and the champagne was dissolving the underlying metal.

Physicians, Doctor Isbister said, are frequently the first to become aware that a patient's environment is causing his illness. He urged doctors to report their suspicions to public health officials.

Doctor Trosko, a specialist on the biological effects of radiation, urged doctors "to foster your patients' social awareness" of environmental problems.

HEALTH SHOULD BE SOUGHT as an end, not a means, he said. The ancient Greeks, he noted, regarded health as "perfection and self-sufficiency," whereas in modern America, "it means self-sufficiency — the capacity to do socially useful work."

MSU's new Center for Environmental Quality, Doctor Trosko said, wants physicians to consider what they want to do in this area and to help them become more effective.

Dean Hunt said it has become appropriate for physicians to work for environmental quality, not only as informed citizens but also in their actual practice. The reason, he explained, is because health is no longer regarded as merely the absence of disease but as maximal well being.

"Promotion of life quality is what medicine has become all about," Dean Hunt said.

MD Placement Notice

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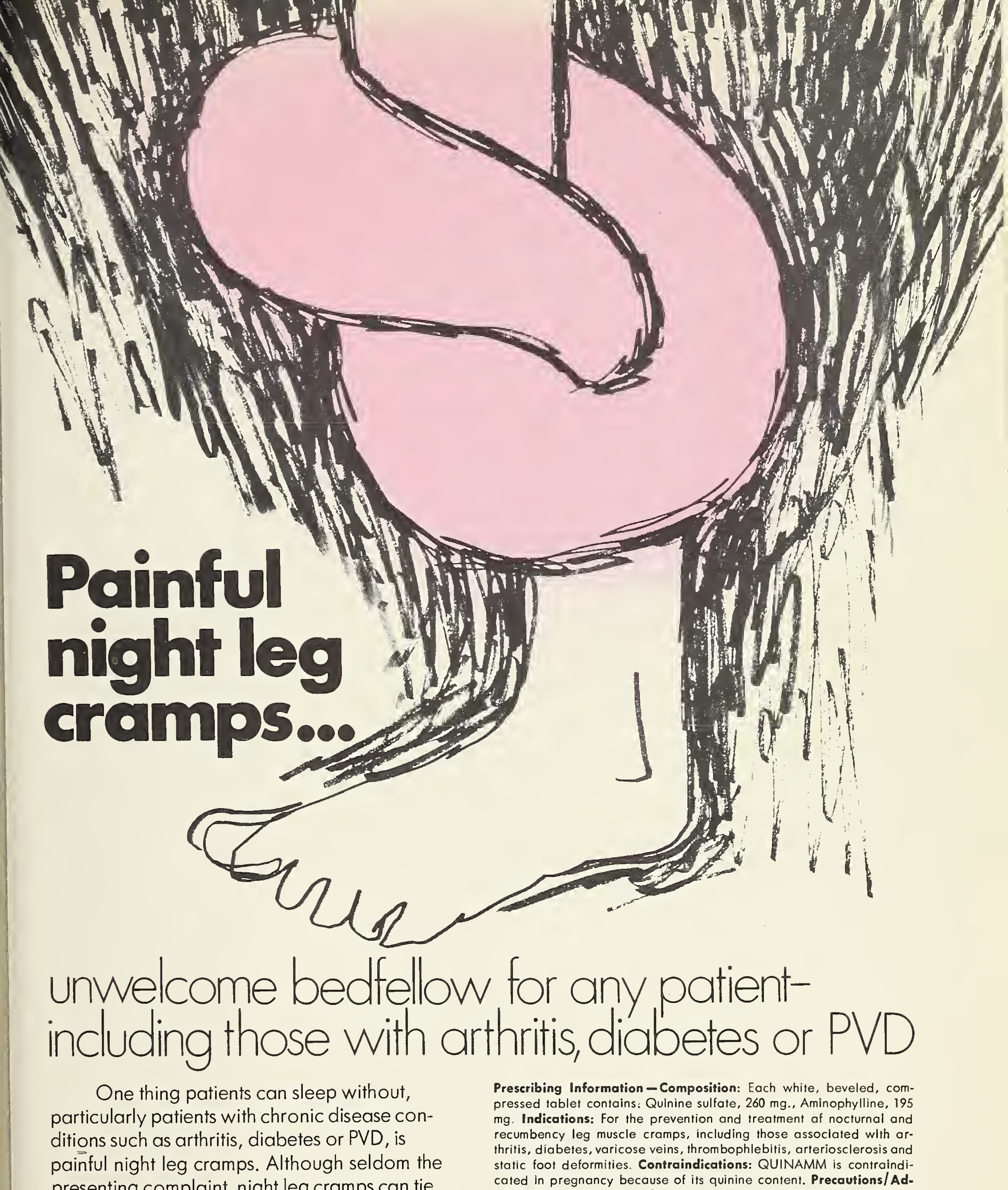
712 Abbott Rd., P.O. Box 1010
East Lansing (Phone: 337-1615)
(No charge for this service)



Painful night leg cramps...

unwelcome bedfellow for any patient—including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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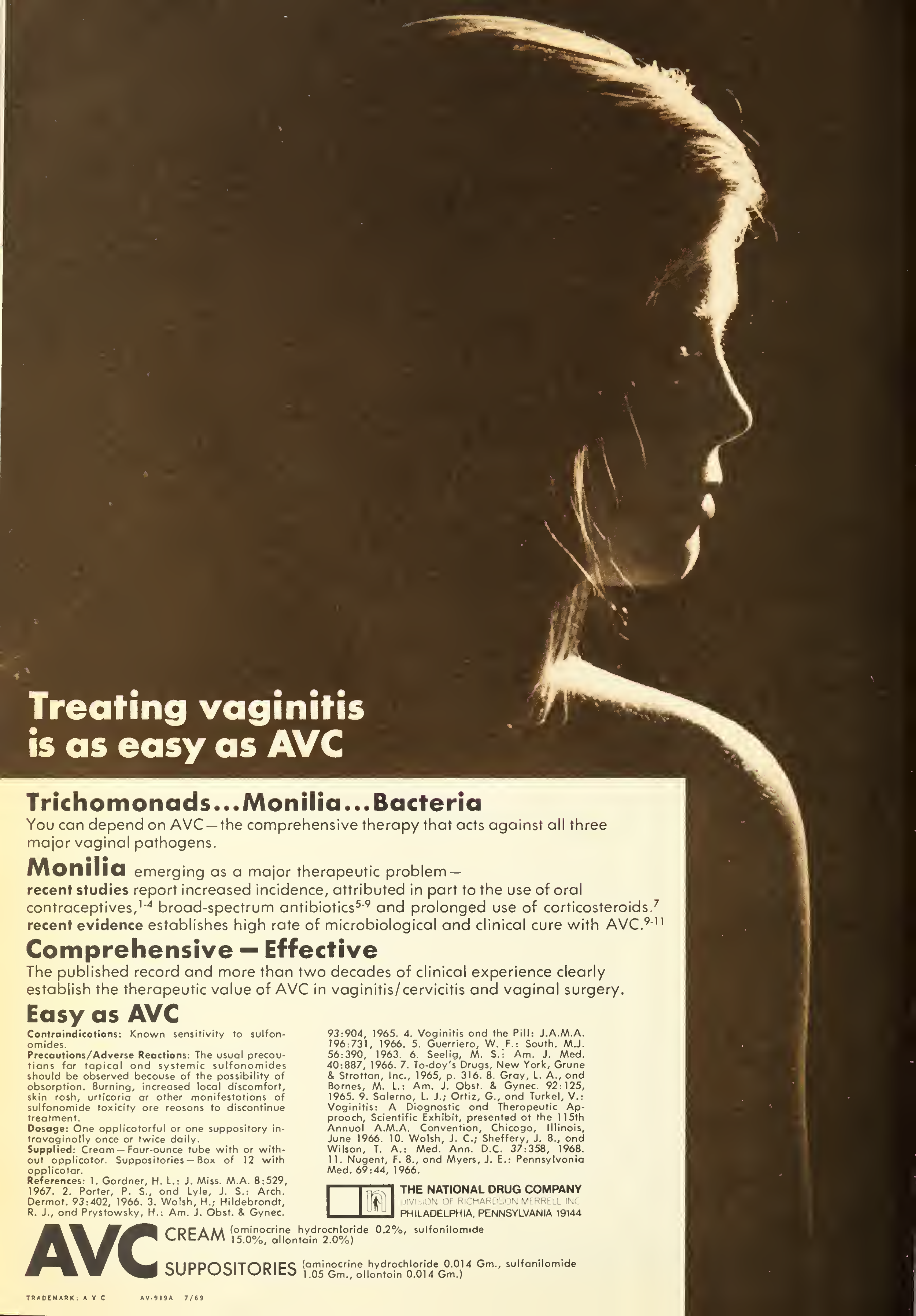

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Contraindications: Known sensitivity to sulfonamides.
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Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.
References: 1. Gordner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Wolsh, H.; Hildebrondt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Strottan, Inc., 1965, p. 316. 8. Gray, L. A., and Bornes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Wolsh, J. C.; Sheffery, J. 8., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. 8., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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Novahistine® LP decongestant

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DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

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WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

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NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

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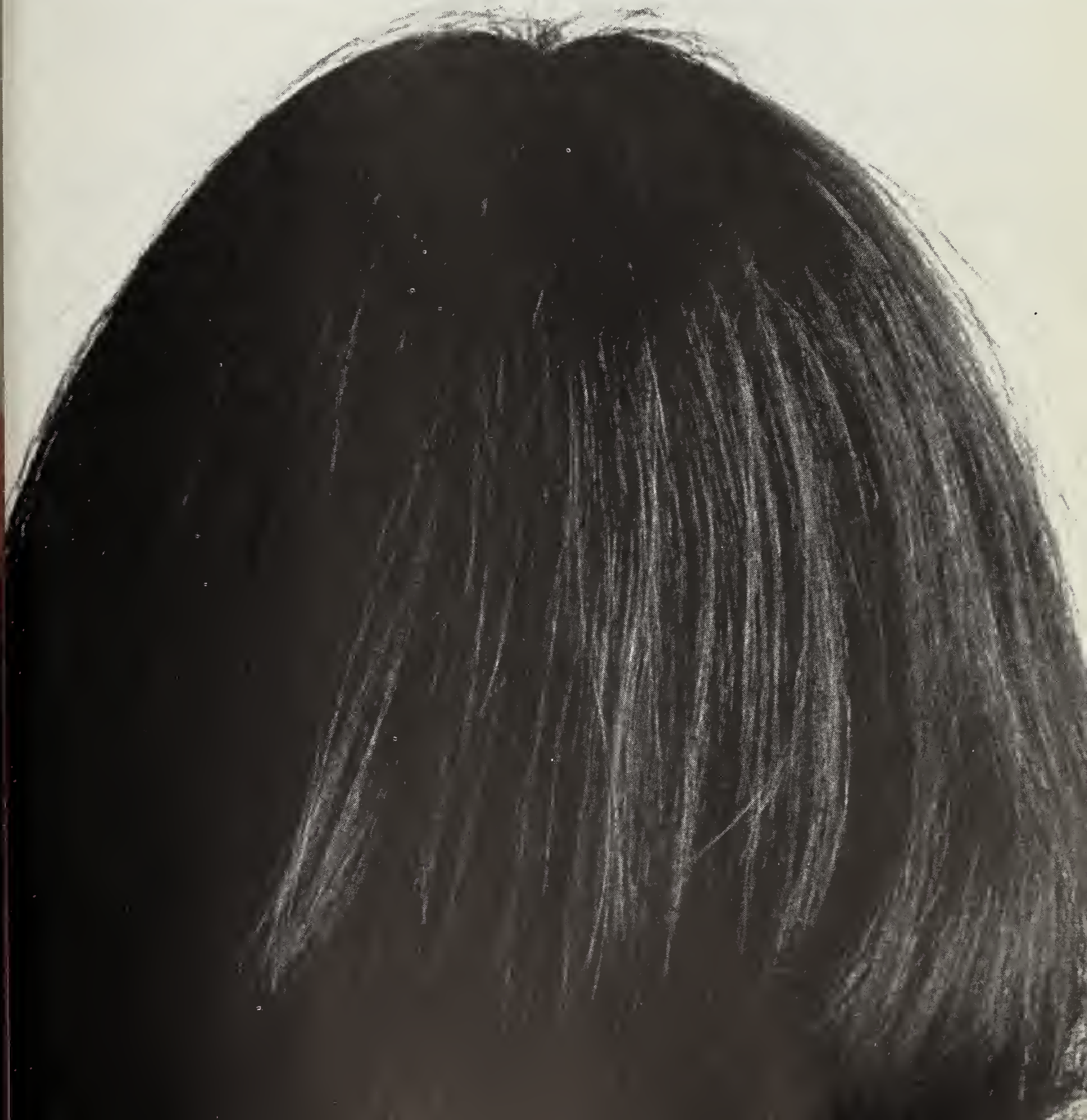
I adore this house.
My in-laws are great.
The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobemate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamete) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker
her underlying anxiety
and tension can surface
and intensify under the
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rearing a growing famil
Especially when she's
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You can help her over
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Equanil can help reliev
tension, ease anxiety—
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MAKE YOUR RESERVATIONS EARLY — SPACE STRICTLY LIMITED!

Michigan Physicians Urged to Help In Survey of Handicapped Children

BY JUDITH MARR
MANAGING EDITOR

Michigan physicians are an important resource for a state-wide survey of the educational needs of all handicapped children currently being conducted by the State Board of Education.

The survey of the educational needs of all types of handicapped children is being conducted through all Michigan school districts according to Act 220 of the Public Acts of 1969. The results will enable the State Department of Education to recommend new legislation that may need to be passed to guarantee that all handicapped children's educational needs are met.

Doctors Can Play Part

According to Marvin Beekman, Lansing, director of special education for the Department of Education, doctors can play a very important part.

"If they know of youngsters with problems they are urged to notify the intermediate school district office, particularly if they know the child is needing services and not getting them," says Mr. Beekman.

Mr. Beekman emphasizes that the privacy of the individual need not be violated, particularly in the case of emotionally and mentally handicapped children.

"We have definitely recommended that the districts not gather the names of the disturbed children," Mr. Beekman continues. "The space for names has been crossed out on the form."

Mr. Beekman has emphasized to the school districts that names only be collected when the handicap may be medically restored, and in any case, names are not to be reported to the state level, but are to remain on the local level.

"We have no need for names at the state level," he says. "We just want the statistics."

Robert J. Mason, M.D., Birmingham, MSMS president, urges Michigan physicians to help out with the survey.

Doctor Mason Supports Survey

A member of the board of the Michigan Association of Emotionally Disturbed Children, Doctor Mason says, "The survey is an educational project and something we've got to do by law. Some feel the confidentiality of the individual is being violated, but that is not the idea."

Plans call for the school districts to have completed their surveys and drawn up their own plans for needed programs by Sept. 1, 1970. The Department of Education is to submit by Jan. 1, 1971, their report of the findings, including any recommended legislation which may be needed.

The survey is a bit behind schedule, Mr. Beekman admits. Reports from the first phase — the survey of the types and numbers of handicapped children — were just beginning to come into the education department in mid-April, when they were supposed to be completed.

Mr. Beekman attributes this partly to the short amount of time his department was allowed to prepare and distribute the survey forms. Other sources say some school districts are reluctant to carry out the survey, believing they will violate the privacy of the individual.

"The biggest thing that has come out of this survey so far is that it has forced communities and school districts to look at their programs for handicapped children and to come up with a program planned to meet their children's needs," says Mr. Beekman. "Then we can go to the legislature and say, 'This is the problem and here's what we'd like to do to help.' "

MHC-SPONSORED SMOKING WITHDRAWAL CLINICS MULTIPLY

Smoking withdrawal clinics, initiated by the Michigan Health Council, are spreading to several Michigan cities following a successful start at E. W. Sparrow Hospital in Lansing.

The Sparrow Hospital format consists of three evening meetings each week for three weeks, led by specialists in the fields of dietetics, psychiatry and thoracic diseases. The intensive withdrawal sessions are sponsored by an inter-agency council of representatives from health agencies and schools.

A similar program has been organized in Ann Arbor at the Veterans Administration Hospital, with one meeting per week for five weeks. Eventually, it is hoped to hold three meetings per week for three weeks, as in Lansing.

Plans were underway late in April for a program in Owosso identical to the Sparrow Hospital withdrawal series. Another identical series was to start June 1 in Kalamazoo.

MAILBAG

Michigan Medicine invites letters of 300 words or less for publication. Communications should be addressed to the Publication Committee, Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823. Unsigned letters will not be considered; but signed letters will be printed anonymously if the author so requests.

More Second Thoughts About Blue Shield

To the Editor:

The Blue Shield Record for December matter-of-factly announced that office imprinters for use with subscriber plastic I.D. cards were being shipped to participating physicians free of charge and that these imprinters were available for purchase at Blue Shield's cost when all participating physicians had received theirs.

Apparently, this policy, like so many other policies of Michigan Blue Shield in the recent past, has aroused considerable comment and controversy. One Blue Shield official when questioned about this policy of distribution of imprinters, answered that "this was not discriminatory, simply an advantage of being a participating physician."

It seems that Blue Shield and the physicians of Michigan are having difficulty reaching agreement nowadays on matters as simple as the meaning of words. Hopefully, when non-participating physicians begin to provide their Blue Shield patients with itemized bills, including diagnoses, in lieu of completing the Doctor's Service Report or alternatively directing the patient to a local Blue Shield office with his plastic I.D. card to have the DSR properly stamped and then brought to the physician's office, Blue Shield will agree that this is not "discriminatory," but simply "an advantage" of being a non-participating physician.

In the light of Blue Shield's increasingly arbitrary and restrictive actions, many physicians are beginning to have second thoughts about the medical profession's historical relationship with Blue Shield and record of close cooperation. Many physicians have now come to feel that there is no longer any justification for their continuing to do much of the administrative work of a financial giant named Blue Shield.

Sincerely yours,
Louis R. Zako, M.D.

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* 1904 - 1967

Doctor Masters' Editorial On Blue Shield Draws Comments

To the Editor:

Your "An Editorial About Blue Shield" in the April 1970 issue of *Michigan Medicine,* raises some interesting questions.

I wonder if there are any physicians in this country who can stand up and say: TO HELL WITH ALL OF YOU SOCIAL PLANNERS! Rights imply obligations. If health care is a decreed right, the grantor of that right has an obligation to actually provide it, or, at least, the means for its provision. To refer to the average physician as politically and economically naive is a euphemism — the word STUPID is more appropriate.

I wonder if there is anyone associated with the politics of the Michigan State Medical Society who would get up and say that the very basis of its existence is one reason Blue Shield is in difficulty, i.e., the notion of the service contract. Perhaps this concept had validity when Blue Shield was founded, but today? What about indemnity contracts? How about deductible contracts? What about limits?

A freeze on charge levels and a roll-back on fees would have validity if it also applied to the brick layer, the insurance executive, each legislator, the president of the United States, each building custodian, the money lender, the plumber, in short: if we were *all* politically, economically, intellectually and socially equal.

"Blue Shield broke?! The only alternative is Universal Health Insurance!" It's intriguing to speculate *what would have happened if medicine were truly organized.* What if Walter Reuther were head of the American Medical Association instead of the United Automobile Workers?

Very truly yours,
Edward T. Glowacki, M.D.
Grosse Pointe

9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
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M.D. Suggests Journal Should Be Reference At All Hospitals

(Editor's Note: Recently MSMS received a letter from a Midland physician offering some observations about the MSMS journal and the suggestion that hospital libraries should subscribe. We quote portions of the letter.)

"Do Michigan hospitals training interns receive *Michigan Medicine*? I called Miss Rose Gage, librarian, Midland Hospital Association, who tells me they are dependent upon staff doctors who may from time to time bring in their personal copies.

"The MSMS publications are not bound for the library. This significant void needs attention.

"*Michigan Medicine* is such a unique production containing a broad coverage of material of value in helping M.D.s to better function in community service programs leadership, that I think and recommend that all hospital libraries retain bound copies as resource to staff physicians and interns in training. I know of no private physician or other agency in this community that preserves bound copies in the medical library.

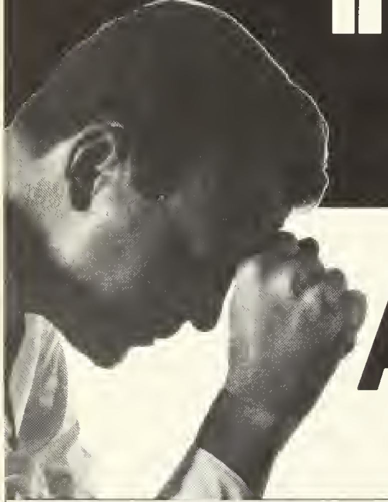
"I am proud and appreciative of the continued efforts of MSMS staff to provide a balanced resource program which highlights attention on the physician's responsibility in physician-patient and community public relations and communications. To me it is an important leadership role which only practicing physicians can exercise efficiently and productively.

"Best wishes for your continued success and efforts."

G. Fred Moench, M.D.
Midland

Major Events On the Calendar For Michigan's Medical Assistants

Sept. 26-27, 1970	Annual Fall Educational Seminar, The Campus Inn, Ann Arbor
Jan. 30-31, 1971	Annual Winter Educational Seminar, The Ramada Inn, Saginaw
April 30-May 2, 1971	Annual Meeting, Weber's Motor Inn, Ann Arbor



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The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

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T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society

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Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Contraindications – Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low

References: 1 **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence Clin Med 12 69, 1966. 2. **Dublin, M F.** Treatment of impotence with methyltestosterone-thyroid compound West Med 5:67, 1964 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence Cen Prac 25-6, 1962 4. **Hellman, L., Bradlow, H L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone J Clin Endocr 19 936, 1959 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79 863, 1958 6 **Osol, A., and Farrar, G. E.** United States Dispensatory (ed 25). Lippincott, Philadelphia, 1955, p 1432 7. **Wershub, L. P.** Sexual Impotence in the Male Thomas, Springfield, Ill., 1959, pp 79-99.

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about doctors

Doctor Weil Calls For Support Of Research Programs

William B. Weil, Jr., M.D., East Lansing, has called on pediatric and academic societies to band together to devise and defend programs that will win increased federal support for research and the training of physicians. The health of the nation's children is otherwise at stake, claims the president of the Society for Pediatric Research, who is also chairman of the Department of Human Development at Michigan State University.

James F. Dooley, M.D., Flint,
president-elect of the Genesee County Medical Society, has been appointed to a one-year term on the Mead Johnson Awards Committee of the American Academy of General Practice. The seven-member awards committee is responsible for administering an annual $12,000 grant to the academy from Mead Johnson and Co. to aid young physicians in completing a year of general and family practice.

John W. Henderson, M.D., Ann Arbor,
professor and chairman, Department of Ophthalmology, University of Michigan Medical School, has been elected to the board of the National Society for the Prevention of Blindness, Inc.

William Hewes, M.D., Adrian,
has been cooperating in the Lenawee Area Vocational-Technical Center's Health Occupations Course for Lenawee County teenagers. The students assist four days a week in the offices of physician, dentist, the local hospital and industrial clinic and on the fifth day share their experiences in a classroom setting. The purpose is to gain exposure to health careers.

William Jend, Jr., M.D., Detroit,
is new first vice president of the Industrial Medical Association. Medical director of Michigan Bell Telephone Co., Doctor Jend is former chairman of the MSMS Committee of Occupational Health.

Karm C. Kerwell, M.D., Stephenson,
was honored recently by his townspeople, who held a testimonial dinner marking his more than 50 years of service to the community as its sole doctor. In November, 1968, MSMS presented Doctor Kerwell with a 50-year award. Doctor Kerwell has been active in his community and now is in semi-retirement.

Paul T. Lahti, M.D., Pontiac,
former chairman of the MSMS Governmental-Medical Care Programs Committee, will give a talk at the Chicago AMA summer convention. His topic will be "Early Ambulance."

Paul Lowinger, M.D., Detroit,
psychiatrist and director of outpatient services at Detroit's Lafayette Clinic, has been named to head the state-supported drug abuse program at Marine Hospital, Detroit. From there he is to plan and develop drug care programs throughout the state.

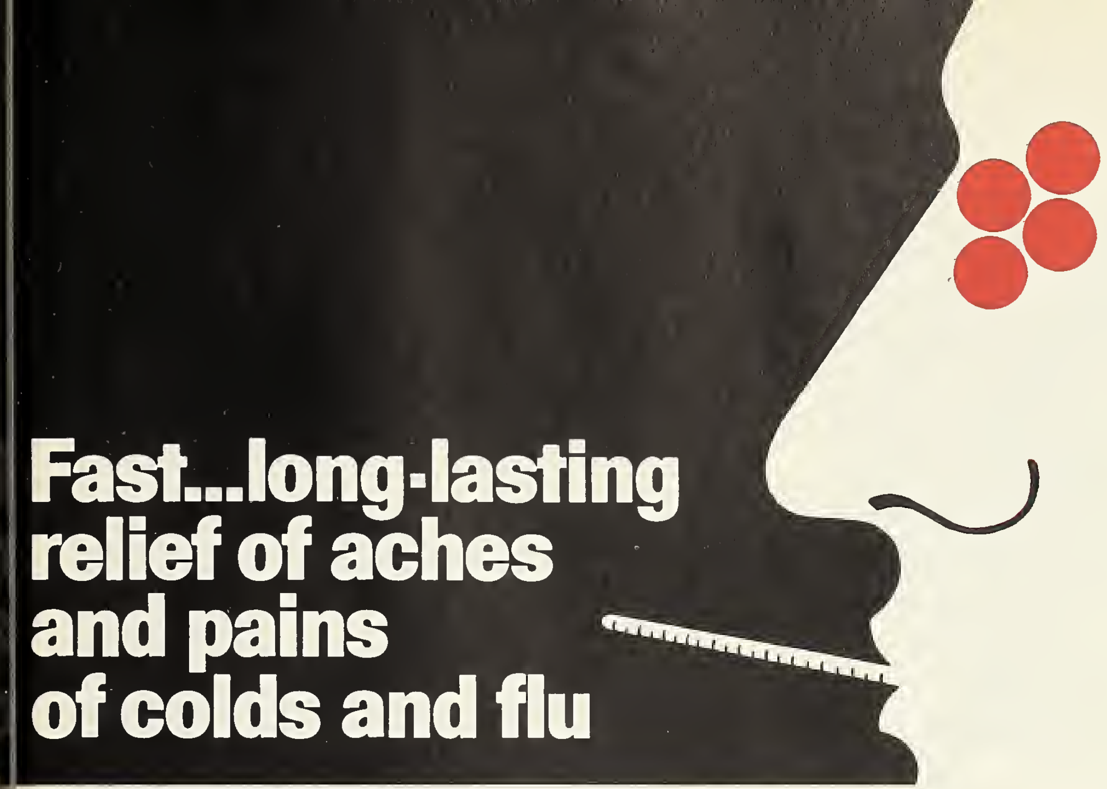
Harold J. Magnuson, M.D., Ann Arbor,
was accorded the highest honor in the field of industrial medicine recently when he was presented the Knudsen Award for the physician who has attained distinction in the field of occupational medicine and hygiene. Doctor Magnuson is associate dean of the School of Public Health at the University of Michigan.

John C. McCabe, Detroit,
president of Michigan Blue Shield, has been elected treasurer of the Board of Directors of the National Association of Blue Shield Plans. He was selected at the association's annual meeting in Miami Beach.

Several Michigan Physicians
are on the program for the National Conference on Cancer of the Colon and Rectum Jan. 7-9, 1971, in San Diego, Calif. They are H. Marvin Pollard, M.D., Ann Arbor; James V. Neel, M.D., Ann Arbor; Daniel J. Fall, M.D., Ann Arbor; William Martel, M.D., Ann Arbor, and Robert C. Horn, Jr., M.D., Detroit.

Boston Physician Selected for Passano Award

The Passano Foundation, of Baltimore, selected Paul C. Zamecnik, M.D., Boston, to receive the $7,500 Passano Award for 1970, one of the highest awards in American medicine. Doctor Zamecnik, a Harvard professor of oncologic medicine, was cited for his pioneering investigations that opened the process of protein synthesis to direct study, a chemical process in both normal and tumor or cancer cells.



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editorial viewpoints

Medical Assistants Celebrate Society's 20th Anniversary

Michigan's 850 medical assistants are celebrating their 20th anniversary this year. They formally marked the occasion with their 20th annual convention late in April at the Pontchartrain Hotel, Detroit.

Founded in September, 1949, the Michigan State Medical Assistants Society had an original membership of 203 persons organized in eight county societies. Now 22 Michigan counties have organized medical assistant groups, and the society has just officially had its name changed to the American Association of Medical Assistants, State of Michigan.

Four Michigan physicians are active supporters of the state medical assistants group, serving on the Advisory Committee. They are G. E. Millard, M.D., chairman, Detroit; F. C. Cretsinger, M.D., Kalamazoo; B. H. Alford, M.D., Plymouth, and V. V. Bass, M.D., Saginaw.

A good medical assistant works side by side with the physician serving the patients.

The good medical assistant scores high in many areas of responsibility:

1. The medical assistant is the doctor's official hostess; responsible for the patient's comfort.

2. The medical assistant is the doctor's ambassador; his personal representative to those who phone in, or come to the office.

3. The medical assistant is a diplomat, possessing tact at all times.

4. The medical assistant is a scheduler; handling appointments to eliminate as much waiting in the reception room as possible, and scheduling as many patients as the doctor can handle efficiently.

5. The medical assistant often is the doctor's secretary; handling correspondence, filing, etc., and even scanning medical literature for items of special interest to her physician-employer.

6. Many medical assistants handle the billing and collection of fees. Statements should be itemized and sent regularly. Financial records should be accurate, and records maintained accurately.

7. The medical assistant is a keeper of secrets. She must never repeat information she might have about a patient's condition. Confidences must be respected.

The medical assistant, I feel, must be friendly, gracious, calm. A good office personality is essential — and should include compassion and understanding.

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Orient Adventure Can't Be Matched, Says Doctor Blain

"The MSMS Orient Adventure trip to Japan and Hong Kong is a trip which cannot be matched anywhere," says Alexander Blain, III, M.D., Detroit, MSMS travel and medical seminar chairman.

Doctor Blain is urging all members of the medical society, the Michigan Association of the Professions and their families to sign up for the trip, departing Oct. 5.

The 14-day luxury Orient Adventure costs $898 per person, and includes round-trip jet fare, a complimentary cocktail party on arrival, deluxe hotels, full American breakfasts and gourmet dinners, five oriental hosts to assist with sightseeing, shopping, golfing and nightclubbing.

Registration forms were printed on page 453 of the May journal. A comprehensive medical seminar on a wide variety of medical interests has been arranged in conjunction with the vacation plans.

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in memoriam

Edwin C. Galsterer, M.D.
Saginaw

Edwin C. Galsterer, M.D., Saginaw obstetrician and gynecologist since 1932, died April 1 at the age of 69.

Doctor Galsterer was an active member of the MSMS Committee on Maternal and Perinatal Health, which in 1969 recognized him for his sponsorship of the excellent Saginaw-Midland-Bay counties Regional Maternal Mortality Evaluating Committee.

Doctor Galsterer served several terms as chief of staff of St. Luke's Hospital, Saginaw, and was a key figure in its planning and development. He also established a Galsterer Memorial Library fund at the hospital.

Doctor Galsterer was a past president of the Saginaw County Medical Society, a fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists, and a diplomate of the American Board of Obstetrics and Gynecology.

He was a graduate of the University of Michigan Medical School.

Benjamin G. Holtom, M.D.
Battle Creek

Benjamin G. Holtom, Battle Creek physician since 1923, died March 27 at the age of 81.

Doctor Holtom, a specialist in ophthalmology, otology, rhinology and laryngology, was honored by MSMS in 1967 for 50 years in practice. He was graduated from the University of Michigan Medical School in 1917.

Doctor Holtom was former president of the Calhoun County Medical Society, former chief of staff at Leila Hospital, Battle Creek, and was a member of the American College of Surgeons and the Michigan Triological Society. He served three terms as a member of the MSMS House of Delegates.

Harry Lewin, M.D.
Southfield

Harry Lewin, M.D., Southfield general practitioner, died March 27 at the age of 78.

Doctor Lewin had practiced medicine for 50 years before his retirement six years ago. He was a graduate of the University of Illinois Medical School. He was affiliated with Brent General and Highland Park Hospitals.

Harold E. Mayne, M.D.
Saginaw

Harold E. Mayne, M.D., Saginaw orthopedic physician and surgeon from 1939 until his retirement four years ago, died April 1 at the age of 61.

Doctor Mayne was a graduate of Wayne State University School of Medicine and was fellow of the American College of Surgeons. He was a former chief of staff at St. Luke's Hospital in Saginaw and was also affiliated with Saginaw and Midland General Hospitals.

Gerald A. Wilson, M.D.
Detroit

Gerald A. Wilson, M.D., long-time Detroit physician, died March 30 at the age of 79.

Doctor Wilson practiced for 50 years before his retirement in 1955. He was a graduate of Wayne State University College of Medicine and had been affiliated with Grace Hospital, where he had been vice chief of surgery.

Doctor Wilson was affiliated with the American College of Surgeons and the Detroit Academy of Surgery and had three sons practicing medicine.

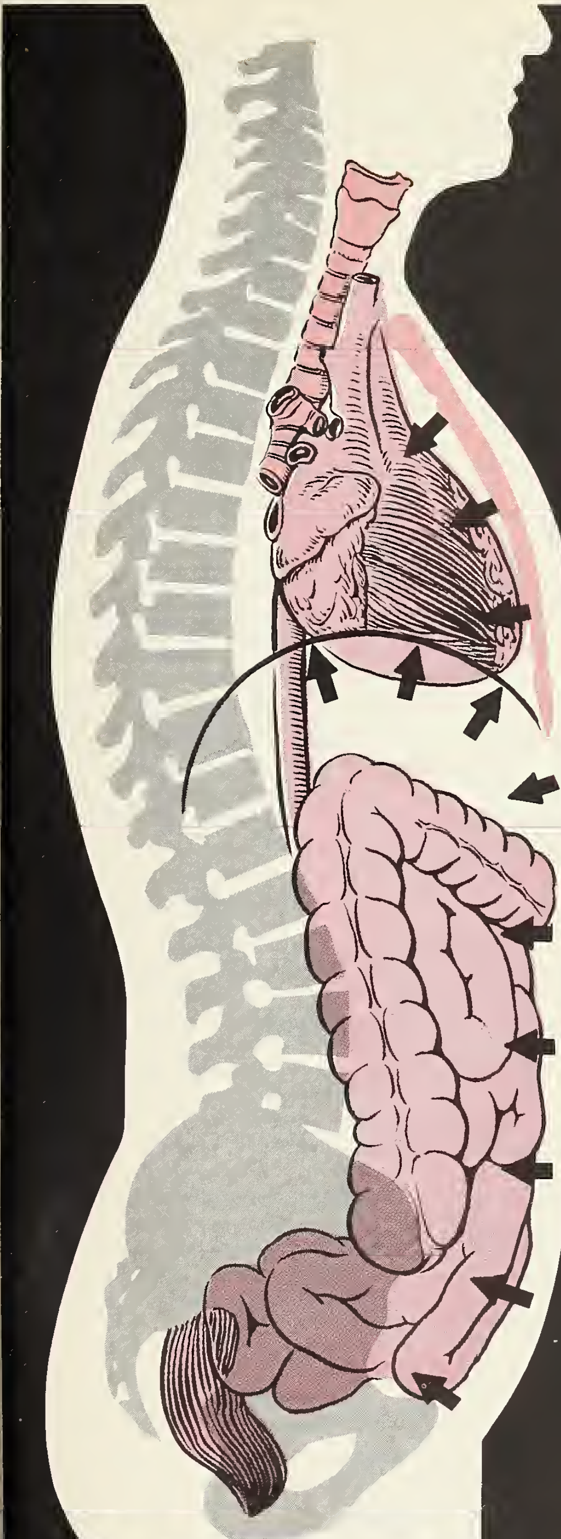
Simon H. Sauter, M.D.
Detroit

Simon H. Sauter, M.D., Detroit physician for more than 50 years, died April 27 at the age of 84.

Doctor Sauter was a graduate of the Fordham University School of Medicine. He was on the staff of North Detroit General Hospital and was a member of the Maimonides Society.

MICHIGAN MEDICINE ON MICROFILM

Microfilmed copies of current as well as all back issues of *Michigan Medicine* are available through University Microfilm Services, a subsidiary of Xerox Corporation. The 35 mm film fits all standard viewers and provides the JOURNAL in miniature at a savings on binding and storage costs. Write for information or send orders direct to University Microfilm Services, 300 North Zeeb Road, Ann Arbor, Michigan 48106.



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*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice*, 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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Index to Advertisers

Allergy Immunology International 543
Arch Laboratories 538
Arnar-Stone Labs 471
Breon Laboratories 537
Bristol Laboratories 477, 532, 533
Brown Pharmaceutical Co. 534
Burroughs-Wellcome & Co. 508
Campbell Soup Co. 515
Classified Ads 542, 543
Dow Chemical Co. 525
Hoechst Pharmaceuticals 541
Hynson, Westcott and Dunnings 467
Import Motors 519
Ingram, G. A. Company 539
Lederle Laboratories 468
Lilly, Eli and Co. 478
Mallard, Inc. 509, 510
Medical Protective Co. 501
Mercywood Hospital 531
Michigan State Medical Society 529
National Drug Co. 499, 523, 524
Plainwell Sanitarium 512
Poythress, Wm. P. and Co. 507, 526
Robins, A. H. Co., Inc. 518
Roche Laboratories .... Cover IV
Schering Corp. 503, 504, 505, 506
Searle, G. D. and Co. 516, 517
Smith, Kline and French Laboratories 513
Stratton, Ben P. 535
University of Michigan .... Cover II
Walker Corp. & Co. 520, 521
Wyeth 527, 528

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BY HERB AUER, EXECUTIVE EDITOR

Medical societies should involve more members in their projects and programs because there are at least three advantages.

Alton Barbour, Ph.D., director of communications at the University of Denver, lists these reasons for involvement:

Quality—groups make better decisions than individuals do.

Acceptance—those who work on an idea are more willing to accept it.

Ideation—as the number of persons working on a problem increases, the opportunities for new ideas increase geometrically.

* * *

Michigan, according to MSU Economics Research D. I. Verway, has 4.66 per cent of the nation's personal income, 4.4 4.34 per cent of the population, 4.15 per cent of the physicians in private practice, and 3.88 per cent of the physician specialists.

* * *

Richard F. Manegold, MD, Associate director, Operations and Development, Division of Regional Medical Programs, Bethesda, Md., declares that:

"The health care system of tomorrow will have continuing education as a central component rather than as a luxury of questionable relevance to the health care system," he said.

"Now, continuing education is viewed as the country cousin," he said. "It lacks the medieval trappings, processions, and rituals of formal education, and, more importantly, it lacks institutionalization. Nevertheless, in the years ahead, continuing education must become the central fact of a quality medical care system or, for that matter, any system in our complex society."

This quotation is from a recent issue of the American Hospital Association *Volunteer Leader.*

* * *

Irving Rubin, director of TALUS (Detroit Regional Transportation and Land Use Study), wrote an interesting feature recently for the *Birmingham Eccentric.* In part, he said:

"Many of our larger cities will be covered by plastic domes and the climate within will be controlled; our homes and transportation vehicles will also be climactically controlled as will much of our clothing. The quantity and quality of goods and services available to us will be virtually unlimited.

"But unless we begin soon to make some major changes in the way in which we approach our relationships to each other as individuals; and the relationships of our group of communities to each other, to the metropolitan area, and to the rest of the world, the quality of life will leave much to be desired."

* * *

The Association of American Medical Colleges in a recent *Datagram* reports that "Of the 252,633 graduates of active U.S. medical schools, 42.8% are located in the state where they were educated, 14.9% are located in states contiguous to their state of graduation, and 42.3% are located in other states. Graduates of medical schools throughout the country have chosen to reside in California. In terms of migration, California is the number one recipient from 21 medical schools in the U.S. One private school (Creighton) has a larger percentage of its graduates in California (26.1%) than in the state in which it is located (14.1%). California has retained a larger percentage of its graduates than any other state. Of 14,162 graduates of its active schools, 10,964 or 77% have remained in the state."

* * *

"Before we are physicians we are trustees, as well as beneficiaries of a great heritage of freedom, a set of values, and a way of doing things that is called the American philosophy of life and government," writes Walter H. Judd, M.D., former congressman, in the current issue of *Texas Medicine.* Doctor Judd suggests, "Perhaps our most urgent task is to re-examine the essence of our American philosophy of life and government, and the faith out of which it grew."

* * *

Following are some extracts from an article in a recent issue of *Pharos* by Mal Rumph, M.D., of Fort Wayne, Texas:

"All students should meet their citizenship responsibilities in the academic community. Only when a majority of students become active will the activity be representative of that student body. I am well aware of the difficulties to be met in engendering such participation for I have been working at the job for several years. Just like their elders many students are too lethargic to become informed — or to do anything about it even though informed.

* * *

Recently we received a letter providing some information we had requested from a Michigan doctor. The note was handwritten and closed with a postscript:

"P.S. — If you can't read this, take it to your nearest pharmacist."

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